

**LEADERSHIP CHALLENGES ENCOUNTERED BY NURSE UNIT MANAGERS IN A
PRIVATE HOSPITAL IN GAUTENG PROVINCE**

by

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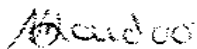
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DECLARATION

I declare that **LEADERSHIP CHALLENGES ENCOUNTERED BY NURSE UNIT MANAGERS IN A PRIVATE HOSPITAL IN GAUTENG PROVINCE** is my own work and that all sources that I have used or quoted have been indicated and acknowledges by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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LEADERSHIP CHALLENGES ENCOUNTERED BY NURSE UNIT MANAGERS IN A PRIVATE HOSPITAL IN GAUTENG PROVINCE

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ABSTRACT

This study investigated the leadership challenges encountered by nurse unit managers and factors enhancing leadership in their units. Currently in South Africa's private hospitals, nurse unit managers face challenges such as financial management, cultural diversity, new roles and technology. The aim of the study was to develop a support strategy for unit managers to achieve success in their leadership role.

This study was conducted at a private hospital in Gauteng Province, South Africa. A qualitative research approach was followed. Data were gathered using semi structured individual interviews with a purposive sample of six operational unit managers with one and more years working experience as unit managers. Qualitative open coding for data analysis methods and presentation were employed.

Three themes emerged from the findings namely, factors influencing the leadership role of the unit manager, the challenges encountered by unit managers in their leadership role and the needs of unit managers. The factors influencing the leadership and management roles were related to the challenges encountered by nurse unit managers in running their units. The findings indicate that a key need required of the unit manager is support and direction from executive management. From the needs expressed by the nurse unit managers, ideas were formulated by the researcher to support the development of a strategy to support the unit managers in their leadership role. The strategy includes eight key elements and is presented in the section that follows.

Key words:

Challenges; leadership; leadership role; nurse unit manager.

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Dedication

This study is dedicated to the following people who inspired me to pursue and complete my master's in nursing leadership:

- *In memory of my late mum, Rungee Naiker, who believed in me making a difference in a nursing career and epitomised the true meaning of caring, commitment, and endeavour to preserve through life's journey.*
- *All nurse unit managers I have worked with in the, past and will work in the future. The important role that they play every day, often in the face of significant challenges and constraints, has inspired me to fulfil this dissertation. I believe it will add meaning to the value of leadership of nurse unit managers.*

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LIST OF ABBREVIATIONS

AANA	American Association of Nurse Assessment
CNS	Clinical Nurse Specialist
DA	Democratic Alliance
DART	Daily Acuity Review Tool
DNAR	Do not actively resuscitate
EPD	Employee performance development
HR	Human Resources
IOM	Institute of Medicine
PA	Personal Assistant
RSA	Republic of South Africa
SANC	South African Nursing Council
UM	Unit Manager

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Leadership is a social transaction in which one person influences others (Roussel & Swansburg 2009:620). According to Marquis and Huston (2015:146), effective nursing leadership has been credited with improving work environments, ensuring greater nurse satisfaction, lowering nurse turnover and improving the quality of patient care. However, a lack of strong leadership in healthcare systems has limited innovation needed to create solutions to the new and complex problems of unit management that the future healthcare brings.

As pointed out by Daft (2014:4), leadership influences relationships among leaders and followers who intend to make real changes and ensure outcomes that reflect their shared purposes. People involved in the relationship want substantive changes, thus leadership involves creating change and not maintaining the status quo. The change sought is not dictated by leaders but reflect purposes that leaders and followers share. Daft (2014:4) further indicates that leadership is shared among leaders and followers with everyone fully engaged and accepting higher level of responsibility. Therefore leadership involves influence, intention, personal responsibility and integrity, followers, shared purpose and change.

An important aspect of leadership highlighted is influencing others to come together around a common vision; and involves the influence of people to bring about change toward a desirable future (Daft 2014:6). This explains explicitly the concept of followers. Followers are an important part of the leadership process and all leaders are sometimes followers as well. Furthermore, it is worth noting that effective leaders think for themselves and carry out assignments with energy and enthusiasm. They are committed to something outside their own self-interest and they have the courage to stand up for what they believe (Daft 2014:5).

Leadership is succinctly summed up by Muller (2009:153) as:

- The act of influencing others.
- Engaging a set of people referred to as followers.
- Regarding a joint course of action.
- Intending to bring about a collective outcome with a specific desired effect within a given context.

1.1.1 Key facets for quality leadership

Ward (2002:121) and Jooste (2009:33) highlight the following as key facets of quality leadership:

- Focus: Effective leaders stay focused on outcomes they wish to achieve, mission, vision and strategy of the organisation, and build the capacity of the organisation to achieve it.
- Authenticity: Leaders who are authentic attract followers even when viewed as being highly driven and difficult to work for.
- Courage: Effective leaders take great courage to overcome the challenges they meet as they are constantly being challenged by others, their team, customers, public and other stakeholders.
- Empathy: Effective leaders know how to listen empathetically, thus legitimising others input. This promotes consensus building and builds strong teams.
- Timing: Leaders know correct timing for critical decisions.

1.1.2 Key leadership styles

The typical leadership styles are authoritarian, democratic, laissez-faire and participative leadership; whilst the new approach to leadership is transformational leadership. They are described as follows:

- Authoritarian leadership: The leader is restrictive, authoritative or directive; and thus controls all information and makes all decisions. The emphasis is on the task or goal

(Morrison 1993:97). Authoritative leaders mobilise people toward a vision and are considered the most effective overall leaders.

- Democratic leadership: The leader is people orientated and focused on human relations and teamwork (Swansburg & Swansburg 1999:465). He or she builds effective work groups, emphasises the values and dignity of individual group members. Democratic leaders seek input from employees and as a result build consensus through participation. Also known as participative leadership, this style encourages participation from everyone but the leader has the final say in the end decision.
- Laissez-Faire leadership: The leader has no leadership skills and is unable to direct staff towards a goal achievement (Muller 2009:158).
- Participative leadership: This style makes a compromise between authoritarian and democratic style of leadership. The leader presents own analysis of problems and proposal for action of staff for comments and criticisms. The leader makes final decision by staff (Gillies 1989:375).
- Transformational leadership: The leader has a special ability to bring about innovation and change in followers and organisations (Jooste 2009:85). He or she is an empowering leader who is highly suited to the health care professions, characterised as being caring and highly ethical (Sofarelli & Brown 1998:202). Transformational leadership is needed for the current challenges faced in the healthcare sector and is critical to a successfully run institution. In the context of nursing, transformational leadership is evidenced to be used to address challenges to improve quality outcomes for patients and staff; which heighten overall organisational effectiveness (Roussel & Swansburg 2009:621). The role that nurse unit manager holds is critical to contributing to executive decisions within the healthcare organisations, representing nursing staff to organisation management and facilitating mutual trust and effective communication between nursing and other clinical leadership. Goleman (1998:96) identified the following four distinct sub-styles within the transformational leadership umbrella:
 - *Affiliative leadership*: Affiliative leaders seek to form emotional bonds with the followers by offering positive feedback and creating a sense of belonging.
 - *Coaching leadership*: Coaching leadership focusses on developing people for the future.

According to Goleman (1998:97), transformational leadership in health care enhances nurse satisfaction, promotes a positive work environment and reduces staff turnover.

1.1.3 The roles of a unit manager

Muller, Bezuidenhout and Jooste (2006:45) indicate that the unit managers' roles were based around the clinical management of the hospital units; whereas the current roles are to manage the overall business of the units which includes overseeing all aspects of operating a unit within a health care facility, from supervising nursing staff to monitoring patient care. The unit managers need to have extensive clinical experience, prior administrative experience, and training and expertise in both nursing practice and unit management. The unit managers also need strong communication skills, diplomacy and the ability to take leadership of any situation in order to fulfil their roles. Some of their duties are as follows:

- Supervisory duties: Nurse managers handle all supervisory duties for the unit, overseeing registered and licensed practice nurses, nursing aides, medical clerks and support staff. They set work schedules, delegate assignments, assign tasks and evaluate employee job performance, as well as conduct disciplinary processes for employees who do not fulfil their job requirements or provide inadequate patient care. Nurse unit managers often mentor less experienced nurses, as well as offering clinical and career advice. They set goals and standards for the unit, and may hold regular staff meetings in which they give directions or discuss areas for improvement.
- Clinical duties: Nurse managers establish standards of nursing care for the unit, applying evidence-based standards and health care research. They monitor patient care to ensure it meets the facility's standards, and review patient records to analyse the effectiveness and efficiency of the care provided by the unit. If a nurse has a question or concern about a patient's care, the unit manager may consult the patient's physician or recommend treatment options. Unit managers not only monitor overall care, they may review an individual patient's case. They also address questions or complaints brought forward by patients or their families.
- Administrative duties: Nurse managers create and oversee budgets for the unit, including personnel, supplies and other expenses. They ensure the department is well-stocked with medical supplies, including medications and equipment. In some

instances they interview and hire employees, in addition to creating training and staff development programmes. They represent the unit's interests, consulting with senior management if the staff has questions or concerns, recommending changes and improvements, and offering the unit's opinion regarding proposed changes or decisions under consideration by the facility's leadership staff.

1.2 BACKGROUND TO THE RESEARCH CONTEXT AND PROBLEM

According to Walton (2012:29), it is necessary for leaders to possess emotional intelligence. Organisations develop leaders' emotional intelligence by enhancing their self-awareness, self-management, social awareness and social skills through training and exposure to leadership approaches and practices within their practice environment. Nurse unit managers need to use their leadership behaviour to positively influence organisational outcomes and to effectively make the interrelationship between developing nursing practice, improving healthcare and optimising patient care outcomes.

Professional nurses employed as unit managers are in charge of various departments in the hospital and reporting directly to the nursing service manager. However, it is not clear if they are given autonomy to successfully lead their units. The roles and functions of unit managers working in hospital departments are regulated by the South African Nursing Council (SANC) according to the Regulation R2598, for the scope of practise for registered nurse (SANC 2005:R2598, as amended).

Various leadership styles and theories are relevant to nursing practise. However, there is no definite evidence on which theory is most effective (Rolfe 2011:54). The flexibility of situational leadership, allows unit managers to adopt many different leadership styles and theories as necessary (Giltinane 2013:39). Unit managers are faced with many different situations every day and no particular leadership style is suitable for all situations. Therefore unit managers should be flexible in their leadership styles and adapt to fit different circumstances and situations.

Nurse unit managers oversee all aspects of operating a unit within a health care facility, from supervising nursing staff to monitoring patient care. They facilitate, monitor and review strategic themes of the balance score card and quality improvement projects.

They support and coach staff as per individual development plans and promote staff satisfaction. The unit managers need to nurture relationships between staff, nursing management, management, multidisciplinary team and stakeholders. They need extensive clinical experience, prior administrative experience, and training in both nursing and management. They also need strong communication skills, diplomacy and the ability to take leadership of any situation.

1.3 RESEARCH PROBLEM

The role of the unit manager is ever evolving, especially in the private sector, possibly due to added responsibility of ensuring financial sustainability; and recruitment and retention of staff. Matlakala, Bezuidenhout and Botha (2014:1) explain that nurse unit managers are exposed regularly to huge demands to fulfil the many roles expected of them. The observation is that, unit managers, whilst provided with the leadership role, still have to obtain instruction from nursing service managers with regards to their leadership role. In the hospital under study, unit managers from different sections have been observed not be able to make independent decisions, follow-through and come up with solutions to problems without being directed by the higher authorities.

The observation is that unit managers seem to be unable to perform their leadership roles effectively; because they are also not fully empowered to function independently in their leadership roles. In some instances, the unit managers would step down from their positions and roles, or even move to other units where they would not take leadership roles. The assumption was that the hierarchy sometimes brought about challenges; such as giving the unit manager responsibility for leadership in the unit, with limited or no authority to successfully achieve their leadership roles. Unit managers, even if eager to meet the leadership roles, often are challenged by the work context.

Currently unit managers have difficulty in transitioning to the expected leadership role due to some key challenges to leadership such as high turnover of staff, lack of adequate budgets and inadequate patient care related to lack of skilled and competent staff. However, it is not clear if they are given autonomy to successfully take the leadership role in their units. The argument in this study is that unit managers are responsible for providing leadership in their units, and therefore need support to fulfil

their leadership roles. The question is what can be done to assist the nurse unit managers to achieve success in their leadership roles?

1.4 AIM OF THE STUDY

A research aim is a description of what the researcher hopes to attain through the research study (Polit & Beck 2012:93). This study aimed to develop a support strategy for unit managers to achieve success in their leadership roles.

1.4.1 Research objectives

Research objectives are formulated to guide research and therefore reflect what the study sets to achieve (Burns & Grove 2010:150). The objectives for this study were to

- explore the challenges encountered by unit managers in their leadership roles
- identify and describe the factors that influence nurse unit manager's leadership role
- identify and describe the needs of the unit managers in their leadership role

1.5 SIGNIFICANCE OF THE STUDY

This study focused on the challenges in leadership as encountered by nurse unit managers in a private hospital setting. Exploring this topic in detail added value to understanding the current gaps in leadership in the nursing sector; in particular in this specific private hospital. The understanding of the challenges made possible for the suggestion of a strategy to assist and meet the needs of unit managers with regard to leadership roles. Key leadership competencies were identified in terms of training, education and professional development for the unit managers, which may assist the hospital executive management to develop unit managers' leadership roles. This may link to ensuring the activities of the unit managers are enhanced to facilitate the provision of quality patient care.

1.6 DEFINITION OF CONCEPTS

This section seeks to define, introduce and explain the key concepts. For the purpose of this study the key concepts used are defined below.

1.6.1 Challenge

A challenge is a demanding situation with a combination of circumstances at a given time (Collins Thesaurus of the English Language 2002). Matlakala et al (2014:2) indicate that a challenge relates to those problems and difficulties that unit managers' encounter in their units. In the context of this study the challenges include the execution of the unit managers' leadership roles as well as staff management, patient issues and operational concerns.

1.6.2 Leadership

Leadership is a process of influencing the activities of an organised group, in its effort towards goal setting and goal achievement (Roussel & Swansburg 2009:731). Sullivan (2012:41) postulates that leadership involves the use of interpersonal skills to influence others to accomplish a specific goal. In the context of this study, leadership refers to unit managers' ability to influence employees towards attainment of goals.

1.6.3 Nursing unit managers

In the context of this study the nursing unit managers are professional nurses registered with the South African Nursing Council (SANC) and employed as unit managers in charge of various departments in the hospital and report directly to the nursing service manager. The unit managers are responsible for the overall leadership of the units, the management of nursing care to patients, all nursing staff within the unit and resources associated with healthcare delivery in the unit. The unit managers are held accountable for the quality of patient care in their units and performance management agreements that outline their operational management responsibilities.

1.6.4 Private hospital

In this study it is a hospital that it is controlled by a single practitioner or by a private group and the associates. It is a hospital that operates for profit.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

The study was based on Maxwell's (2010:129) four pillars of leadership. According to Maxwell (2010:9), there are four key features of successful leadership; namely relationships, equipping, leadership and attitude. The author explains these four factors as follows:

- Relationships – connecting, respecting, knowing, encouraging, listening and serving with others, sharing experiences, trust, reciprocity and mutual enjoyment.
- Equipping – deciding to equip the team, gathering the best team, paying the price, doing things together, empowering the team, praising the team, evaluating the team, creating new opportunities and giving chances for success.
- Leadership – getting influence through hard work, obtaining trust through competence, character and connection, and having a vision.
- Attitude – leaders evaluate their attitude, change bad attitudes, change thought patterns for the better and choose to have a right attitude.

These pillars of leadership are described further; and used to explain and contextualise the findings later in this study.

1.7.1 Research paradigm

This study was informed and guided by the constructivist paradigm. The constructivist paradigm has its roots in philosophy and the human sciences and it is centred on the way in which human beings make sense of their subjective reality and attach meaning to it (Holloway & Wheeler 2010:25; Hesse-Biber 2010:455). Constructivist paradigm acknowledges the existence of many socially constructed, subjectively-based realities that consist of stories or meanings grounded in natural settings and it is typically associated with qualitative research.

In this study subjectivity based realities are factors that influence nurse unit managers' leadership role and the challenges encountered by unit managers in their leadership roles. The assumption of the study was that a description of the needs of the unit managers will assist to develop a support strategy for unit managers to achieve success

in their leadership roles. An assumption is a basic principle that is accepted as true on the basis of logic or reasoning without proof or verification (Polit & Beck 2012:528).

1.8 INTRODUCTION TO RESEARCH DESIGN AND METHOD

According to Polit and Beck (2012:741), a research design is the overall plan for addressing a research question, including specification to enhance the study's integrity.

A qualitative approach was followed (Streubert & Carpenter 2011:21), aimed to adequately answer questions about the what, how or why of the leadership in nursing (Bowling 2009:380). A qualitative research is a systematic approach used to describe experiences and situations from the perspective of the person in the situation (Grove, Gray & Burns 2012:67).

The study was conducted at a private hospital in Gauteng Province. The hospital is a P3 level facility, which is 23 years old; has a bed capacity of 264, with 15 units and an average occupancy of 80%. The units are amongst others medical, surgical, maternity, ICU, high care, paediatrics, maternity, theatres, accident and emergency unit.

The target population was nurse unit managers working in the proposed hospital for this study. There were 16 nurse unit managers at this private facility who were all recruited; and a purposive sample of 6 nurse unit managers were included in the study based on the leadership positions they occupied in their units. Semi-structured individual interviews were conducted with the nursing unit managers at operational level. The interviews were audio recorded with the permission of the participants (see Annexures D and E).

With regards to ethical considerations, ethical clearance was obtained from the Higher Degrees Committee of the Department of Health Studies, University of South Africa and permission to conduct the study was sought from authorities of the proposed hospital. Voluntary and informed consent, privacy, confidentiality, justice, beneficence and non-maleficence as well as scientific integrity were observed throughout the study. Full descriptions of the stated ethical issues as well as the measures taken to address each of the issues, data management and analysis, and details regarding the measures taken to ensure the trustworthiness of data are described in chapter 3 of this study.

1.9 STRUCTURE OF THE DISSERTATION

The dissertation is organised into five chapters as follows:

Chapter 1: Overview of the study

Chapter 2: Literature review

Chapter 3: Research design and methods

Chapter 4: Analysis, presentation and description of the research findings

Chapter 5: Conclusion and recommendations

1.11 CONCLUSION

In this chapter, the introduction, background, problem statement and introduction to methodology were discussed. The next chapter presents the literature background for this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is a critical summary of existing knowledge on a topic of interest, often prepared in order for the research problem to be placed in context (Polit & Beck 2008:757). Brink, Van der Walt & Van Rensburg 2012:71) describe literature review as written sources relevant to the topic of interest. A literature review was conducted to determine factors and challenges affecting nurse unit managers' leadership roles. In accordance to nursing leadership, this literature review, defines leadership and outlines the qualities and functions of an effective nurse unit manager.

2.2 DEFINITION OF LEADERSHIP

Leadership is a vital element that transforms a group into a functioning useful organisation (Talbot 1971 cited in Roussel & Swansburg 2009:621). Stogdill (1986) cited in Roussel and Swansburg (2009:620) define leadership as "the process of influencing the activities of an organised group in its efforts towards goal setting and goal achievement". According to Bennis (2002) cited in Jooste (2009:25), leadership is a complex process by which a person influences others to accomplish a mission, objective and directs the organisation in way that makes it more cohesive and coherent. In the healthcare sector, leadership attributes to be applied are beliefs, values, character, knowledge and skills. Effective nurse unit managers are those who engage others to work effectively in pursuit of a shared goal.

Roussel and Swansburg (2009:625) highlight that nursing leadership is a process in which a leader inspires staff to work together, using appropriate means to achieve a common mission and goal. The researcher understands that the nursing managers are responsible for influencing staff to achieve the purpose and objectives of the healthcare institution; and accordingly nursing managers are influenced by the vision and mission of the institution and the services to be rendered.

A common theme identified in the definitions of leadership is that leadership involves influencing the attitudes, beliefs, behaviours and feelings of other people (Spector 2006 cited in Curtis, Vries & Sheerin 2011:306). Effective leadership in health care is emphasised by a number of authors (Greenfield 2007:159; Sutherland & Dodd 2008:570; Carney 2006:80). Nursing leadership is pivotal for effective nursing care and represents the largest discipline in health care (Marquis & Huston 2015:145; Sullivan & Garland 2010:50). Leadership exists in all health sectors; it affects positive change and achieves high standards of patient care as stipulated in job titles such as nursing service manager or modern matron (Sullivan & Garland 2010:53).

A study by Matlakala et al (2014:1) researched the challenges of critical care unit managers in the public and private hospitals. The sample only included unit managers in critical care units and some challenges identified from their findings include: shortage of intensive care registered nurses and lack of clarity on roles and responsibilities of the unit manager, workload, stress and lack of protocols in the units. This impacted on effective leadership and management of the units by the unit managers.

Literature indicates that there are many challenges confronting nurse unit managers at present time, such as the new roles and responsibilities, financial understanding constraints and emphasis on education (Curtis et al 2011:306). Due to the shortfall in the availability of critical care nurses, most permanent ICU nurses are overworked (Matlakala et al 2014:2), this compromises the quality of critical care nursing.

2.2.1 Requisites for successful leadership

The characteristics for excellent nursing leadership are identified Dunham and Fisher (1990) cited in Curtis et al (2011:306) as administration competence, adequate education, business skills, clinical experience and understanding of leadership principles. Marquis and Huston (2015:3) highlight that decision making is one of the criteria in which a unit manager's expertise is judged. The unit manager's time is spent critically examining issues, solving problems and making decisions. The quality of the decision that a unit manager makes, is the factor that often weighs more heavily in their success or failure. According to Marquis and Huston (2015:5), decision-making, problem solving and critical thinking are learned skills that improve with practice and consistency.

The effective leader is aware of the need for sensitivity in decision making. The unit manager must be able to identify the appropriate people to include in decision making and suitable theoretical model used to guide quality decisions. Unit managers should develop a systematic, scientific approach to problem solving that begins with a fixed goal and ends with an evaluation step (Marquis & Huston 2015:25). Therefore, it is important for nursing managers to ensure a problem solving attempt is guided by dedicating much time and energy to identifying the root of the problem (Marquis & Huston 2015:3).

Linn, Khaw, Kildea and Tonkin (2012:18) consider clinical reasoning as essential to integrate and apply different types of knowledge to weigh evidence, think critically about arguments and reflect upon the process used to arrive at a diagnosis. Clinical reasoning uses both knowledge and experience to make decisions at the point of care". Marquis and Huston (2015:4) are of an opinion that insight, intuition, empathy and willingness to take action are additional components of critical thinking. All unit managers should be critical thinkers with flexibility, openness to new ideas, intuition, caring, empathy, thinking outside the box, creativity and willingness to take action.

Nurse unit managers are also clinical leaders in their units. Cook (2001:33) defines a clinical leader as being "directly involved in providing clinical care that continuously improves care through influencing others". Stanley (2006:308) explains that a clinical leader is an expert nurse leader who leads staff to better health care. Giltinane (2013:35) suggests that "the essence of clinical leadership is to motivate, to inspire, promote values of National Health Service, empower and create a consistent focus on the need of patients being attended to".

2.2.2 Leadership theories

There are various leadership theories and different qualities and behaviours that are appropriate in different situations. For example, in nursing some situations require quick thinking and fast action whilst others require time to figure out the best solution to a complicated problem. Various perspectives and theories are explored in this literature review to determine the essential qualities and skills required for effective nursing management (Roussel & Swansburg 2009:622).

Leadership has generated a huge amount of research and theory (Muchinsky 2006:50; Weihrich & Koontz 2005:70). Spector (2006) cited in Curtis et al (2011:307) classifies the theories in the following approaches:

- Trait approach which is concerned with personal traits that contribute to effective leadership.
- Behaviour approach which explores leadership from perspective of the leader and focuses on leader behaviour.
- Contingency approach where leadership is about the interaction between a person (leader), his or her behaviour and the situation. Examples will be Fielders contingency theory and path goal theory).
- Leader member exchange approach which is concerned with the relationships between subordinate and supervisor. Example will be in charismatic or transformational leadership.

While any of these leadership theories can be used to help unit managers lead, some writers have supported the use of transformational leadership as choice for nursing leadership (Bowles & Bowles 2000:69; Sullivan & Garland 2010:66; Carney 2006:85).

2.2.3 Views on leadership

Psychologists define leadership in terms of interpersonal behaviour (Kaiser, Lindberg, McGinnis & Overfield 2012:120). Leadership requires more complex skills than management. Management, on the other hand, emphasises control in terms of hours, costs, salaries, overtime, etc.

Leadership is considered to increase productivity by maximising workforce effectiveness by directing and motivating. Therefore, a unit manager is actually a leader through the expectation of empowering others. Thompson (2012:21) explains that “good management is defined by strong planning, organisational skills and control”, which allows managers to intervene when goals are threatened. The integration of both leadership and management skill is critical to goal attainment.

Dignam (2012:65) asserts that “change is a primary feature of contemporary health care environment”. Therefore managers must be able to shift from a traditional focus on operational task completion to the leadership skill of visioning, motivating and inspiring others, before desired outcomes can be achieved. MacLeod (2012:57) emphasises that “in the face of significant change both sound management and strong leadership skills are essentials to the long term viability of today’s health care organisations. Leaders are those individuals who are out front, taking risks, attempting to achieve shared goals and inspiring others to action”.

Kaiser et al (2012:119) is of the opinion that “the essence of leadership is a social influence process, where; leaders use interpersonal behaviour to motivate employees to commit and give their best effort to contribute to group goals”.

Daft (2014:15) spells out key elements for leadership as follows:

- Direction – Create vision, strategy and maximise opportunity.
- Alignment – Create shared culture, values and learning opportunities. Encourage networking and flexibility.
- Relationship – Invest in people, use personal influence, inspire with purpose and trust.
- Personal qualities – Emotional connections (heart); open mind (mindfulness); listening (communication); non-conformity (courage); and insight into self (character).
- Outcomes – Create change, culture of agility and integrity.

2.2.4 Key leadership styles

The following are the leadership styles:

(a) Autocratic leaders

Morrison (1993:97) cited in Jooste (2009:64) states that an autocratic leader is referred to as restrictive, authoritative or directive. The leader thus controls all information and makes all decisions. The emphasis is on the task or goal, while people are considered secondarily or not at all. Swansburg and Swansburg (1999:465) cited in (Jooste

2009:65) posit that this leadership tends to promote hostility, aggression and decreases initiative. According to the American Association of Nurse Assessment Coordination (AANAC) (2014), the autocratic leadership style is demonstrated when a leader makes all decisions without considering input from staff. As knowledge is viewed as having 'power', critical information may be withheld from team. Autocratic leaders tend to be micro managers. In the nursing sector, autocratic leadership is useful in crisis or complex situations, where quick decisions need to be taken and the patient's health is at stake.

(b) Democratic leadership

Swansburg and Swansburg (1999:465) cited in Jooste (2009:65) view democratic leaders as being people orientated and focused on human relations and teamwork. This leadership increases productivity and job satisfaction. According to the AANAC (2014), the democratic leader encourages open communication and staff are given responsibilities, accountability and feedback regarding their performance. Relationships are of utmost importance to this type of leader, who focuses on quality improvement of systems and processes.

(c) Laissez Faire leadership

According to AANAC (2014), a Laissez Faire leader provides little or no direction and prefers the hands off approach. Decisions made are rarely changed and quality improvements are reactive and not proactive. The appointed leader abdicates leadership responsibility. This leaves staff without direction, supervision or coordination. The leader is passive, inactive and non-directive; furthermore, the leader wants everyone to feel good (Jooste 2009:65).

(d) Participative leadership

The participative style of leadership is a compromise between authoritarian and democratic style of leadership. In this leadership the leader presents own analysis of problems and proposals for action to the staff and invite comments and criticisms. The leader makes the final decision for the staff. The leader retains control over the final decision. This leadership is required when staff involvement is needed if there is

planning to overcome resistance and increase motivation (Gillies 1989:375 cited in Jooste 2009: 65).

(e) Transformational leadership

Transformational leadership is a style of leadership in which the leader identifies the needed change, creates a vision to guide the change through inspiration and executes the change with the commitment of the members of the group (Dolamo 2008:40). The health care industry experiences tremendous change and problems in the sector. The healthcare industry restructures and redesigns ways to ensure effective and quality care to patients. Staff are empowered when they share in decision making and are rewarded for quality and excellence. Cook (2001:35) cited in (Jooste 2009:85) postulates that transformational leadership is key to future nursing development, promotes entrepreneur spirit and innovation. Sofarelli and Brown (1998) cited in Jooste (2009:85) explain that empowering leadership is highly suited for nursing leaders and is characterised as being caring and highly ethical.

A strong set of internal values and ideals are often the hallmarks of transformational leaders. Transformational leaders are capable of motivating employees for the highest attainable goals. Lai (2011:3) described transformational leadership in four dimensions as follows:

Individualised consideration: includes leaders who spend considerable time on nurturing and educating their followers, through which they show self-esteem, respect and serving as trainers.

Inspirational motivation: it enables leaders to encourage their followers to have higher performance. Such leaders are successful in highest expectations of the followers so that they can reach more than what others think.

Idealized influence: includes inspiring thoughts and outlooks, shared treats and difficulties and trust and confidence in the subordinates. The leader applies idealised influence acts in such a way that she/he shows high standards of ethical behaviours.

Intellectual stimulation: transformational leaders encourage their followers to act creatively in solving **problems**.

The AANAC (2014) affirms that transformational leadership is based on building relationships and motivating staff through a shared vision and mission. Transformational leaders have charisma to communicate vision and confidence to act in a way that inspires others. Empowered staff become critical thinkers and are active in their roles within the organisation. A creative and committed staff is the most important assets that nurse managers can develop. In the nursing environment, empowerment can result in improved patient care, fewer staff absenteeism and decreased attrition. Nurses who are transformational leaders have staff with higher job satisfaction and who stay in the institution for longer periods.

Effective nursing leadership has been credited with improving work environments, ensuring greater nurse satisfaction, lowering nurse turnover and improving the quality of patient care. A lack of strong leadership in health care systems has limited the innovation needed to create solutions for the new and complex problems that the future health care brings (Marquis & Huston 2015:146).

Nursing unit managers must acknowledge the importance of their role and the reliance of staff on their leadership in developing their professional skills. Nurse unit managers need to use their leadership behaviour to positively influence the organisation's outcomes, to effectively make the interrelationship between developing nursing practice and improving health care and, optimising patient care outcomes.

A unit manager is example to others, either positive or negative; and therefore must be able to adopt a variety of leadership styles based on the situation. The unit manager needs to act with integrity to set goals, communicate clearly and often to encourage others to recognise the success of staff and inspire them to provide the best of care. The actions of the nurse unit manager will be reflected by staff, in the care rendered to patients, regardless of leadership practised (AANAC 2014).

Rolfe (2011) cited in Giltinane (2013:38) states that leaders should be visible role models and empower staff to become leaders. Empowered staff show increased organisational loyalty, motivation, job satisfaction and promotes a positive work

environment. When staff develop ownership of the goals to be achieved these result in increased staff morale. Transformational leadership allows unit managers to communicate their vision in a manner that is meaningful and reduces negativity. Doody and Doody (2012:12) maintain that traditional nurses have been 'over' managed and inadequately led and that contemporary health care organisations need to be increasingly adaptive and flexible in their leadership approaches. The transformational leadership motivates followers by appealing to higher ideas and moral values to sustain the good, rather than own interest, and where responsibility is shared.

Although transformational qualities are highly desirable, they must be coupled with the more traditional transactional qualities of the day to day managerial roles such as focus on tasks and commitment to delivery of service. Kouzes and Posner (2007:141) state that exemplary leaders foster a culture in which relationships between aspiring unit managers and willing employees can thrive.

(f) Quantum leadership

Quantum leadership is used by a leader to better understand the dynamics of the environments such as healthcare environment. Leaders must work together with subordinates to identify common goals, exploit opportunities and empower staff to make decisions for organisational productivity to occur (Marquis & Huston 2015:63). Quantum leadership suggests that the environment and context in which people work is complex and dynamic and this has a direct impact on organisational productivity. O'Grady (2011:34) emphasises that the health industry is characterised by rapid change and the potential for intra-organisational conflict is high and, the ability to respond to the dynamics of crisis and change is not only an inherent leadership skill, but must be inculcated within the fabric of the organisation and its operation.

2.2.5 Leadership effectiveness

Leadership effectiveness requires the ability to use the problem solving process, maintain employee effectiveness, communicate well, demonstrate leader fairness, competence, dependability, creativity and develop employee identification (Zenger & Folkman 2009:4). According to a study by Rispel and Bruce (2015:117), challenges in the South African nursing profession include weak policy development, leadership and

governance of nursing practice. The environment is said to be fraught with management and quality care problems. A visit by the Democratic Alliance (DA) to a clinic in Hillbrow, Johannesburg, South Africa in 2016, serves to confirm that nurses are frontline of health care, yet little resources are allocated to carry out duties or extend congratulations for tirelessly serving the South African people (James 2016).

One of the flaws in leadership is weak relationships. Maboko (2011:912) indicates that negative relationships among nurse managers and registered nurses, led to registered nurses inability to perform duties effectively and efficiently. Therefore the leadership styles of nurse managers can affect the competency of professional nurses.

Communications within the organisation can also lead to flaws in leadership. The principles for effective communication include elements of clarity of message, use of direct language, encouragement of feedback, acknowledgement of contributions and direct channels of communication. Assertiveness in communication is an important factor in terms of allowing staff to stand up for themselves and their rights without violating the rights of others (Whitehead, Weiss & Tappen 2010:74). To overcome the leadership flaws in relation to communication the leaders should display skilful communication, listening to others, encouraging the exchange of information, providing feedback, communicating a vision for the future and developing oneself and others.

The principles for effective communication include the following elements:

- Aim for clarity and focus to ensure message is understood.
- Use direct and exact language that is easily understood by all.
- Encourage feedback, help staff understand each other and work together better.
- Acknowledge the contributions of others as everyone likes to feel worth.
- Use the direct channels of communication, for example, call a meeting or send an internal memorandum.

Assertiveness in communication is important in that assertive behaviour allows staff to stand up for themselves and their rights without violating the rights of others (Whitehead et al 2010:74). Feedback is essential because the process of giving and receiving evaluative feedback is an essential leadership responsibility, for example, acknowledging work done well, promoting growth and ensuring employee satisfaction

(Whitehead et al 2010:82). Positive and negative feedback needs to be given; and feedback should be given immediately.

A shortage of all categories of and skilled nurses within the National health services is recognised as a negative impact on leadership. The International Council of Nurses (ICN) identifies the global shortage of registered nurses. Sufficient workforce is required to enable health systems to function effectively. According to literature, agency staff are used to alleviate the staff shortage, and these agency staff often display a lack of commitment and decreased standards of quality patient care. Permanent staff work overtime due to the shortage of staff, resulting in them being exhausted and unproductive for normal shifts (Matlakala et al 2014:6; Rispel 2010 cited in De Beer, Brysiewicz & Bhengu 2011:7). Matlakala et al (2014:6) highlight that it is not possible to have competent, trained and experienced nurses because of a global shortage of nurses, especially registered nurses.

Leading the implementation of change is closely aligned to the leadership role of the unit manager. The unit manager should take a leadership role in successfully implementing change. The process of bringing about change has four phases, namely; designing the change, how to implement change, carrying out actual implementation and following through to ensure the change has been integrated into the regular operation of the facility. Change in the health care setting is an inevitable part of living and working. How people respond to change, the amount of stress it causes and the amount of resistance it prevents can be influenced by leadership. If change is handled well by unit managers, it can become opportunities for professional growth and development rather than just additional stress with which nurses cope.

2.2.6 Emotional intelligence

Emotional intelligence refers to the ability to perceive, understand and control one's own emotions well as those of others (Giltinane 2013:35). Jooste (2009:415) proposes that authentic leadership and emotional intelligence is needed to address the complexity of the manager–employee relationship. Leadership in nursing involves the unit manager thinking about their own feelings as well those of staff. The unit managers need to know how to manage themselves and staff which is crucial to running an effective institution (Jooste 2009:142). According to Bellack (1993) cited in Jooste (2009:142), newly

qualified unit managers do not have necessary competencies to cope with today's demanding health sector demands. According to Goleman (1998) cited Jooste (2009:142), some unit managers have the intellectual ability and expertise to do the job, but lack personal competencies of 'emotional intelligence'.

Walton (2012:29) suggests that organisations develop leaders' emotional intelligence by enhancing their self-awareness, self-management, social awareness and social skills. Mayer, Caruso, Salovey and Sitorenios (2001:233) is of the opinion that emotional intelligence develops with age and consists of three mental processes, namely; appraising and expressing emotions in the self and others, regulating emotion in self and others, using emotions in adaptive ways.

Goleman (1998) cited in Jooste (2009:143) expresses the following components of emotional intelligence:

- Self-awareness – The ability to recognise and understand one's moods, emotions and drives as well as their effects on others.
- Self- regulation – The ability to control or redirect disruptive impulses or moods as well as to suspend judgment.
- Motivation – A passion to work for reasons that go beyond money or status and pursue goals with energy and commitment.
- Empathy – The ability to understand and accept the emotional makeup of other people.
- Social skills – Proficiency in handling relationships and building networks and ability to find common ground.

Baggett and Baggett (2005:12) indicate that managers should be leadership 'stars' who consciously address the effect of people's feelings on the team's emotional reality and the way do it. Leaders learn to recognise and understand own emotions and learn how to manage them, channel them, stay calm and clear headed, and suspend judgement until all the facts are in when a crisis occurs. According to Whitehead et al (2010:7), the emotionally intelligent unit manager welcomes constructive criticism asks for help when needed and can juggle multiple demands without losing focus, turning problems into opportunities. These managers listen attentively to others, perceive unspoken concerns, acknowledge other's perspectives and bring people together in an atmosphere of

respect, corporation, collegiality and helpfulness so they can direct their energies toward achieving the team's goals.

2.2.7 Empowerment and leadership

Jooste (2009:222) defines empowerment as the “use of personal potential and competencies for discovering of new expertise; and creating opportunities to apply such competencies”. Empowerment is a necessity in the healthcare sector due to changing staff needs and rendering of quality health service. Unit managers need to be able to make independent management decisions in the operation of the unit. The unit manager uses motivational strategies and participative decision-making to empower staff in the health sector. Management structures to empower staff include further training in supervisory skills, open climate for discussion, collaboration in decision making and creating opportunities for innovation. The empowering unit manager creates a climate of trust with staff and delegating tasks which results in staff becoming independent and empowered. Constant feedback from nurse unit managers contributes to creating a positive work environment.

2.2.8 Transition from industrial to relationship age leadership

A paradigm shift has taken place in the 21st century whereby there is a transition from the industrial age leadership to relationship age leadership. Industrial age leadership is focused primarily on traditional hierarchical management structures and skills acquisition. On the other hand, relationship age leadership focuses primarily on relationship between unit manager and employees, on discerning common purpose, working together cooperatively and seeking information. Key behaviours needed to be displayed for an effective leader include:

- Informational behaviour – representing employees, representing the organisation, public relations monitoring.
- Interpersonal behaviour – networking, conflict negotiation and resolution, employee development and coaching, rewards and punishment.

2.3 THE QUALITIES OF AN EFFECTIVE NURSE UNIT MANAGER

A nursing unit manager is a professional (registered) nurse employed as a person in charge of a specific department or unit in the hospital; and reporting directly to the hospital nursing service manager. The roles and functions of unit the manager are regulated by the South African Nursing Council (SANC) according to the scope of practise for registered nurse as amended (SANC 2005:R2598).

In terms of qualifications, the unit manager has successfully completed (post-basic or post-graduate training) and registered for an additional qualification for nursing administration or nursing management; and is a registered /professional nurse who has formal authorisation to manage a nursing unit by virtue of the post described and designated lines of authority within a nursing service or hospital (Muller 2009:96).

The effective unit manager possesses a combination of qualities, namely; leadership, clinical expertise and business sense (Whitehead et al 2010:16). The combination of the mentioned qualities prepares the manager as a leader for the complex tasks of managing a unit or team as the leadership skills are essential to the unit manager, clinical expertise are required for staff development skills and to assess the effectiveness of their work in term of patient outcomes and business sense is essential for unit managers to be concerned with the bottom line cost of care provided, for example, funding, insurance and private patient care. This is a complex task requiring knowledge of budgeting, staffing and measurement of patient outcomes.

2.3.1 The key responsibilities of the unit manager

- Patient care – providing safe, cost effective and quality patient care in line with clinical governance strategy, evaluate nursing quality indicators and clinical outcomes, ensure effective communication with patients regarding their care.
- Staff leadership and development – fostering an environment where staff are aware of the role they play in the provision of quality patient care and value to organisation. Facilitating staff development (personal and professional), coaching and mentoring of staff.
- Management of costs – management of patient acuities and ensuring cost effective quality care.

- Stakeholder's relationships – building and maintaining effective relationships with doctors, staff, patients and other stakeholders in the healthcare facility.
- Risk management – ensuring compliance with protocols, policies and acts of the hospital.

2.3.2 Roles of the nurse unit manager

According to Matlakala et al (2014:2), unit managers are responsible for the effective and efficient management of the unit, in addition, are often required to function as nursing staff and fulfil other roles in relation to care of the patients. The roles of the unit manager include supervisory, clinical and administrative duties which are explained as follows (Jooste 2009:43):

Supervisory duties

- Overseeing registered and licensed practical nurses, medical clerks and support staff.
- Set work schedules, delegate assignments, evaluate employee job performance.
- Disciplining employees who don't fulfil their job requirements or provide inadequate patient care.
- Establish employee policies and procedures.
- Mentor less experienced nurses, offering clinical and career advice.
- Set goals and standards for the unit.
- Hold regular staff meetings in which they give directions or discuss areas for improvement.

Clinical duties

- Establish standards of nursing care for the unit, applying evidence-based standards and health care research.
- Monitor patient care to ensure it meets the facility's standards
- Review patient records to analyse the effectiveness and efficiency of the care provided by the unit.

- Consult the patient's physician or recommend treatment options regarding questions or concern of patient care.
- Monitor overall care by reviewing individual patient's case or if the patient is not responding to treatment.
- Address questions or complaints brought forward by patients or their families.

Administrative duties

- Create and oversee budgets for the unit.
- Ensure the department is well-stocked with medical supplies, medications and equipment.
- Interview and hire employees.
- Create training and staff development programmes.
- Consulting with senior management if the staff has questions or concerns, recommending changes and improvements.
- Offering the unit's opinion regarding proposed changes or decisions under consideration by the facility's leadership staff.

The unit manager is at the lowest level of management at hospital level which is operational level. Managing a unit is very important for the healthcare service and delivery of care (Muller 2009:95). The unit manager applies the fundamental management activities which is planning, organising, leading and control. These four elements are encountered at all levels of management within the health care services.

The nursing unit manager is responsible and accountable for the management of the unit. The unit manager is responsible for quality of clinical nursing, human resources, financial management, and management of information stocks, supplies and equipment. To ensure the units is running effective and efficient. Nursing unit management occurs within legal and professional ethical i.e. National health act, corporate governance. (Muller 2009:100).

2.4 MANAGEMENT LEVELS

The nursing unit manager functions at first level/operational level management. This is where action takes place and the heart of clinical nursing (Muller 2009:100). The executive level of nursing management is the nursing service manager, which is top level management. The unit manager reports to nursing service manager at a health care service. This is displayed in the diagram depicting leadership in nursing management. The unit manager directly reports to the nursing manager and indirectly reports to the deputy nursing manager. In the current context of hospitals, the organogram of management is displayed as follows:

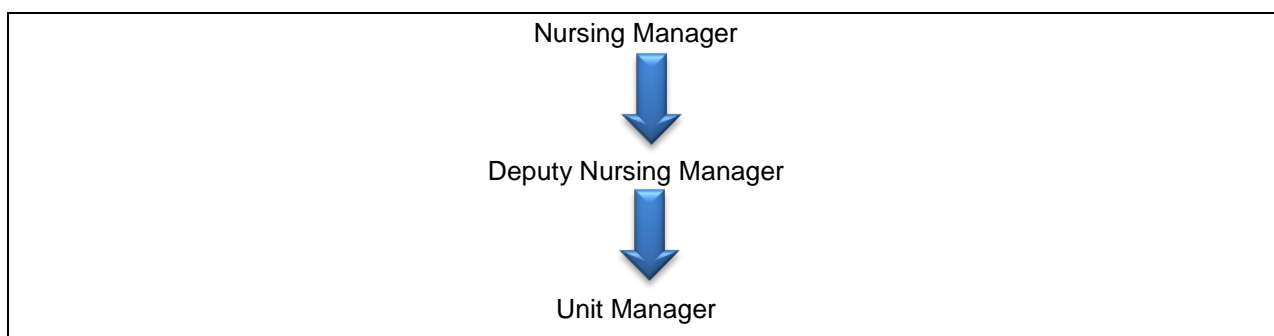


Figure 2.1 Nursing managers' hierarchy

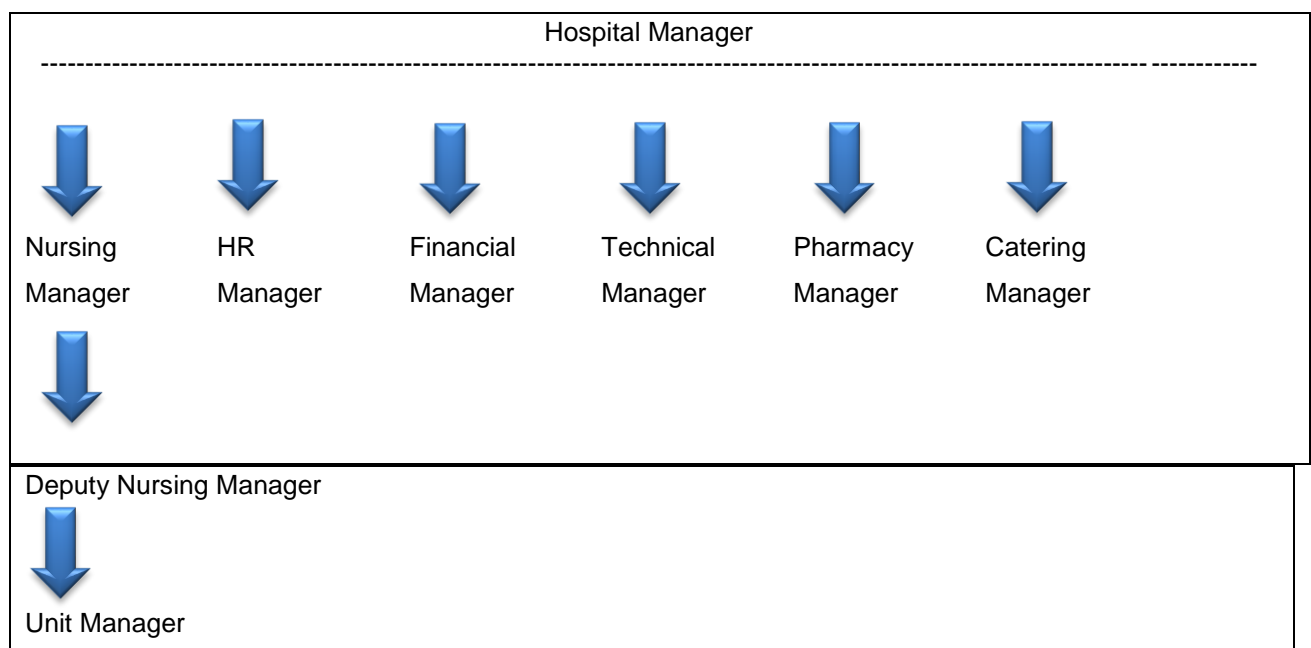


Figure 2.2 Hospital divisions and nursing managers' hierarchy

2.4.1 Management styles

This refers the way a unit manager performs management activities in the nursing unit. This management can be bureaucratic with minimal involvement of the staff or more participative. The general types of management styles utilised include:

- Bureaucratic management – Involves hierarchical structuring, rules and regulations, formal organisation climate and world and labour division.
- Participative management – This involves dynamic involvement of the unit manager in decision making, problem solving, ownership, accountability and empowerment.
- Strategic management – Strategic management requires planning, of a strategic plan, implementation of the strategic plan, evaluation of outcomes, achievement of goals and performance indicators (Muller 2009:102).

2.5 THE FUNCTIONS OF AN EFFECTIVE NURSE UNIT MANAGER

According to Rambur (2015:3), unit managers should be knowledgeable in business, finance skills and understand the importance of pursuing leadership positions to better serve patients, families and communities. Keeping this in mind, nurse unit managers should be given the opportunity to also participate at executive meetings to discuss finance matters. In this respect, nursing leaders require unique competencies collaboration, accountability, team leadership and negotiation skills. They need to have the knowledge and skills to measure quality, safety and customer satisfaction on health care delivery and performance. Nurses are responsible to bring the consumers' voice to the forefront and have a lifelong commitment to human caring (Rambur 2015:5).

In the current work contexts, finance and economics is new way thinking for many nurse leaders. Thus, knowledge of economics and finance provides nurse leaders with binocular vision. Nurse leaders have the knowledge of patients and systems and, are ideally suited for the social responsibility of knitting together the needs of the individual and the society at large, within a landscape that considers health, health care cost and quality (Fraher, Ricketts, Lefebvre & Newton 2013:1812). In addition, all nurse leaders need to possess strategic planning skills, sound clinical knowledge and have the ability to respond to a crisis.

Possession of business acumen, policy making and health finance, which includes the ability to read a financial statement, is critically important (Rambur 2015:3). The nurse leaders in the private sector need to understand patient days, consumable costs, payroll costs, planned hours, actual hours and budgets. Indicative of this new thinking and approach, the Institute of Medicine (2010), Washington, called for the health care system to serve society better through opportunities for nurses to assume leadership positions and to serve as full partners in health care redesign and improvement efforts.

Zachray, Gilbert and Gragg (1995) cited in Ntlabezo, Ehlers and Booyens (2004:34) emphasise that “nurse managers must have the necessary information and preparation to develop strategic financial planning, as the nursing sector accounts for more than half of the health care institutions’ budgets”. Within a South African context, Ntlabezo et al (2004:34) also recognise that nurse managers as leaders in the nursing profession need to contribute effectively to financial management of the health care institution.

2.6 CONCLUSION

Effective leadership is absolutely critical to organisational success in the 21st century. Becoming a better leader-manager begins with a highly developed understanding of what leadership and management is and how these skills can be developed. The nurse unit managers should be coached on leadership skills and unit managers should be able identify knowledge and skills requisite to leadership competencies. The unit manager’s leadership behaviours should include promotion of autonomy and decision making to the staff.

Current unit managers need to possess leadership and visionary skills for organisational success. The future health environment requires leaders to work alongside employees and to have the ability to empower others. The organisational culture need to support initiatives, ensure autonomy and promote creativity in decision making in all sectors of the healthcare organisation.

The unit manager needs to bring diversity into the healthcare organisation, encouraging recruitment of human talent of different categories and work experience, as well as different ethnic backgrounds. Essential elements of education, research quality improvement, practice standards and, competent and independent leadership should be addressed in the future preparation of unit managers.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter explains the research design and methods followed. This includes research population, sampling, data collection, management and analysis. The ethical considerations and measures to ensure trustworthiness in the context of the study design are also described.

3.2 RESEARCH APPROACH

A qualitative research was followed. Qualitative research is a systematic, interactive and subjective approach used to describe life experiences and give them meaning (Grove et al 2012:705). Qualitative research is a situated activity that locates the observer in the world; where researchers study things in their natural settings, attempt to make sense by interpreting phenomena in terms of the meanings people bring to them (Denzin & Lincoln 2011:3). The goal of qualitative research is to understand rather than explain and predict (Babbie & Mouton 2001:53). The researcher wanted to obtain an insider's perspective by allowing participants voice to be heard (Brink et al 2012:120). The aim was to have open ended questions that could assist to guide the participants' responses. Probing questions were utilised to ensure that the participants were able to expand on their understanding and experience of nursing leadership.

Qualitative research begins with assumptions and use interpretive or theoretical frameworks that inform the research problems; thus addressing the meaning individuals or groups ascribe to a social or human problem. Qualitative research was applied owing to the following uses as identified by Creswell (2003:48):

- To empower individuals to share their stories, hear their voices thus minimising power relationships that exists between researcher and participants.
- To understand the setting in which the participants of the study address a problem or issue.

- Better fit for the research problem.

With the qualitative approach, the researcher was able to obtain information from the unit managers on the challenges they encounter daily during the execution of their leadership roles. This approach allowed for open questions and probing, thereby allowing participants a chance to respond in their own words and allowing the researcher to engage more actively with the participants. This was a meaningful process for the participants and allowed the researcher to engage more actively with the participants.

3.3 RESEARCH DESIGN

Research design is a blueprint for conducting a study with maximum control over factors that may interfere with the validity of the findings (Burns & Grove 2009:195). An exploratory and descriptive research design was used to explain the leadership role of the unit managers.

3.3.1 Explorative research

Burns and Grove (2009:313) define exploratory research as research conducted to gain new insights, discover new ideas and/ or increase knowledge of a phenomenon. The exploratory design enabled the researcher to investigate the nature of challenges encountered by unit managers in their leadership role. There was a need for the researcher to present detailed, thick information of the factors that influence nurse unit managers' leadership role as described by the unit managers. Exploratory research increased knowledge of leadership in nursing and provided a basis for confirmatory studies. With explorative research, the intention was to identify concepts relating to the phenomenon and was used where little information is available on the leadership role of the nurse unit manager.

3.3.2 Descriptive research

This provides an accurate portrayal or account of the characteristics of a particular individual, event or group in real life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something

occurs and categorising information (Grove et al 2012:93). In descriptive research a systematic description of the concepts in the context of the study is required (Jooste, 2009:460). The purpose of descriptive research is to describe characteristics of phenomena, relations between variables or relationships between phenomena as accurately as possible. Descriptions can also be grouped according to classification systems or typologies that can be used to compare different responses (Du Plooy-Cilliers, Davis & Bezuidenhout 2014:76).

According to Kumar (2011:10) a descriptive study aims to describe a situation, problem or phenomena systematically; and provide information about certain phenomena, for example, job descriptions of unit managers. In this study the main aim of using descriptive approach was to describe the current situation of nursing leadership, its challenges as well as the major influencing factors which may hamper the most effective nursing care delivered to patients.

3.4 RESEARCH METHODS

According to Schutt (2009:327), research methods focus on the individual steps in the research process and the most objective procedures to be employed. Research methodology indicates how to collect data and analyse data (Du Plooy-Cilliers et al 2014:289). Research methods include the context or study setting, population, sample and sampling procedures, the specific methods used for data collection and analysis.

3.4.1 Research setting

According to Polit and Beck (2012:743), study setting means the physical location and conditions in which data collection takes place. The study was conducted in a 23 year old private hospital in Gauteng province. The hospital has a bed capacity of 264 and the average occupancy of hospital is 80%.The hospital has 15 units, which include amongst others medical, surgical, and maternity, ICU, high care, paediatrics, theatres and accident and emergency.

3.4.2 Population

A population is all elements that meet certain criteria for inclusion in a study (Grove et al 2012:46). Schutt (2009:149) defines a population as the entire set of individuals or other entities to which study findings are to be generalised. The target population for this study comprised of nurse unit managers working in the proposed private hospital in Gauteng. There was a total of 16 unit managers from different specialty units at this private hospital and all of them were recruited for the study.

3.4.3 Sample and sampling method

A sample is a subset of the defined population selected for a particular study or that is used to study the population as a whole (Grove et al 2012:46; Schutt 2009:149). Sampling refers to a process of drawing a representative sample from a population (Polit & Beck 2012:742). A non-probability purposive sampling was used to select the nurse unit managers of the private hospital, based on years and experience in the nursing leadership role. The researcher consciously selected the unit managers at operational level to be involved in the study (Grove et al 2012:365). Purposive sampling was chosen because the intention was to include participants that the researcher had established some contact with and 'trust' with in order to provide a deeper understanding of nursing leadership challenges.

To be included in the study, nurse unit managers were required to have a minimum of one year of experience as a unit manager, be willing to participate in the study and were chosen from different specialty units. From the 16 recruited unit managers, the sample size comprised 6 unit managers; and was determined by data saturation.

3.5 DATA COLLECTION

Data were collected through semi-structured individual interviews and written notes (Annexure E). An interview guide with 5 open-ended questions based on a framework of leadership was used (Maxwell 2010:10). Probing and clarification questions were used to get a full understanding from the nursing unit managers based on the responses to questions given. The interviews were audio recorded with the permission of the participants.

The deputy nursing manager assisted with the coordination of the interviews with the unit managers. The time frame for interviews was 30–45 minutes. The interviews took place in unit manager's office, stockroom and nursing manager's office to provide privacy for the participants and to avoid outside disturbances. Confidentiality was maintained at all times. Reference numbers, dates and times were used to label the audio tapes. The ethical principle of non-maleficence was upheld, as no harm was inflicted upon participants.

3.5.1 Ethical considerations

Ethical approval was obtained from the Higher Degrees Committee of Department of Health Studies, Unisa (Annexure A: approval number: HSHDC 422/2015). Permission to conduct the study and interview the unit managers was obtained from Private Hospital Head Office Ethics Committee and the Management of the hospital (Annexure C). Relevant documentation was provided to the Ethics Committee, namely the research proposal and ethical approval together with the request letter (Annexures A and B).

Informed consent consists of four elements, namely, disclosures of essential, information, comprehension, competence, and voluntarism. These elements were factored in by the researcher. Three major elements for informed consent were considered namely; the type of information needed from the researcher, participant degree of understanding of the research that the participant must have to give consent and the fact that the participant had the choice of whether or not to give consent (Brink et al 2012:38). In order to obtain the participants' consent, the researcher provided the participants with completeness and clear information regarding participation in the study (written and verbal).

The researcher explained the purpose of the study to participants and obtained a signed written informed consent to participate (Annexure D). The right of the participants' autonomy was respected and they were not coerced to participate in the study. The participants were given an option of whether or not to participate (Brink et al 2012:33). They were further informed that they could withdraw from the study at any time should

they decide not to participate. Privacy and confidentiality were maintained in that their names did not appear on the records, both audio and written (Polit & Beck 2008:170).

3.6 DATA MANAGEMENT AND ANALYSIS

According to De Vos, Strydom, Fouché and Delport (2011:397), data analysis is the process of bringing order, structure and meaning to the mass of collected data. The data analysis approach employed was thematic analysis. Audio recorded data were transcribed verbatim and read to gain a complete understanding. According to Hennink and Weber (2013:700), transcription is important in qualitative research process because it transcribes verbatim the participants' own words, language and expressions; and allows the researcher to decode behaviour, processes and meanings attached to people's perspectives.

Data were analysed manually using open coding (Polit & Beck 2008:517-518); and explained by organising the raw data to make meaningful interpretations (Burns & Grove 2009:198). Every effort was made to describe the participants' challenges and needs as they were presented without any attempts to impart partially or with judgement. All the participants' descriptions were considered equally and valued.

The researcher worked with the supervisor of the study to code and identify themes and ideas. Themes were identified using Techs descriptive analyses method (De Vos 2011:297). The content was analysed, highlighted and similar meaning units were identified and grouped into categories. The categories were further grouped into broader themes. The steps taken were as followed:

- The audio records were carefully listened to and compare with written notes.
- Audio recorded data were transcribed verbatim and read through to make sense of the whole.
- Each transcript was read individually and thoughts and topics written in the margin of the document.
- A list of all similar ideas and unique topics were identified and written as meaning units.
- The meaning units were coded as categories with descriptive words.

- The categories were reduced by grouping those that relate to each other into broader topics/themes
- A final decision was made on the themes for each category and meaning units to ensure no duplication occurred.

3.6.1 Measures to ensure trustworthiness

Trustworthiness is defined as the qualitative researcher's degree of confidence in the research findings which persuades others that the findings of the research are worth paying attention to (Tappen 2010:157). To ensure trustworthiness of data the four criteria for establishing trustworthiness of qualitative research as suggested by Lincoln and Guba (1985) cited in Creswell (2013:192) as well as Polit and Beck (2008:539) were used. These included credibility, dependability, confirmability and transferability.

Credibility refers to the accuracy with which the researcher interpreted the data that was provided by the participants (Du Plooy-Cilliers et al 2014:258). This included prolonged engagement and member checking of the findings.

Prolonged engagement refers to activities that invest sufficient time for data collection so that in-depth understanding of the phenomenon of interest and the researcher can also build trust and establish good rapport through prolonged engagement with participants where data collection took place. Prolonged engagement was attained by the researcher who established rapport during the days of recruitment of the participants and whilst seeking permission from the unit managers to participate in the study.

Member checking was done by constantly checking data with the participants. This was done immediately after the interview by summarising the responses to ascertain if it was a true reflection of their responses to determine the accuracy of the findings. The participants were given a chance to validate and verify the researcher's interpretations which were done to ensure all facts were not misconstrued (Brink et al 2012:127). The researcher at the end of the interview reiterated understanding of statements, thereby ensuring no information was misconstrued. The researcher validated the data with the participants by summarising the interview and also asking the participants if what was captured was what the participants wished to share.

Transferability is the ability of the findings to be in similar situation and deliver similar results across different times. This approach allows for generalisation of findings (Du Plooy-Cilliers et al 2014:258). However, in this study the findings are not transferable as the intention of this study was not to generalise to all other units and hospitals; but to provide a guide as to what could assist successful leadership roles in nursing. To ensure transferability of the study results the researcher provided a comprehensive description of the characteristics of the participants and study setting which should enable individuals to evaluate applicability of the results in other settings.

Dependability is used to establish the trustworthiness of the study and audit of the process. (Brink et al 2012:127). The quality of the process of integration that took place between the data collection method, data analysis and the theory generated from the data obtained was fully described. The researcher kept an audit of the process and the supervisor of this study reviewed the research plan and process. Pre-testing the interview guide was done with 2 unit managers. The research methodology was clearly described and comprehensively transcribed interviews were presented in this study.

Confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that the internal agreement between the investigators interpretations and the actual evidence (Du Plooy-Celliers et al 2014:259). It refers to how well the data collected supports the finding and interpretation of the researcher. It indicates how well the findings flow from the data (Du Plooy-Celliers et al 2014:259). The data from the transcribed verbatim notes were shared with participants in order to verify and confirm the accuracy of information captured and the interpretations of nurse unit managers' challenges encountered in their units.

3.7 CONCLUSION

This chapter presented an overview of the research design and methods used in this study; it explains the reasons motivating the chosen research design; and the theoretical foundations of qualitative research methodologies that were applied.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the analysis, presentation and description of data. The chapter begins with a description of the data collection and analysis process. The final sections of this chapter outline the participants' characteristics, the themes and categories that emanated from analysis of the interview data.

4.2 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of this study was to develop a support strategy for unit managers to achieve success in their leadership role. The objectives were to investigate the challenges and factors that influence nurse unit manager's leadership role, and further identify the needs of the unit managers in relation to their leadership role.

4.3 DATA COLLECTION PROCESS AND MANAGEMENT

Data collection involved the precise process of gathering information from the participants, which were later used as evidence to develop a support strategy for the unit managers in their leadership roles. Data were collected through semi-structured individual interviews with six (6) unit managers. The participants were identified through pre-determined eligibility criteria. The recruited participants were given the opportunity to accept or decline the interview as explained in Chapter 3 of the study.

The interviews were conducted on two separate days. The unit managers were from the following six units; Surgical ward, Cardiac Intensive Care Unit, Maternity unit, Neonatal Intensive Care Unit, Paediatric ward and General Intensive Care Unit.

The interview dates were arranged with the deputy nursing manager of the hospital in advance. The unit managers were made aware of the interviews to accommodate their busy unit schedules and not disrupt their routine. The venues where the interviews were

as explained in chapter 3 of this study. The six (6) unit managers interviewed were five (5) females and one (1) male. The interview times ranged from 30 to 45 minutes.

The researcher gave a brief introduction of herself, welcomed and thanked the participants for their availability and willingness to do the interviews. The letters for permission to conduct research from the Head Office (Annexure C) and ethical clearance certificate from the Department of Health Studies, Unisa (Annexure A) were given to hospital manager and nursing service managers. Copies of the letters were shown to the participants before each interview.

The researcher gave a thorough explanation of the purpose and objectives of the study and written consent was obtained from the participants. The informed consent forms were prepared prior to the interview by the researcher and contents were explained to participants to seek their consent (Annexure D). The researcher informed the participants that participation in the study was voluntary and that they were free to withdraw their participation at any time in the interview. Privacy, confidentiality and anonymity were ensured by assigning codes to the participants. The codes were assigned according to the sequence which the interviews were conducted as follows: Unit Manager 1 (UM-1).

The semi-structured individual interviews were audio recorded and transcribed verbatim. Transcriptions were done by the researcher in order to facilitate engagement with data. The audio tapes were identified with dates and categorised UM-1, -2 according to the sequence and dates of the interview as indicated. During the interview the researcher also took field notes. The audio tapes and field notes were stored in a safe place, accessible to researcher only. The opening statement for the interview was "Tell me about your leadership role in the unit". For more questions refer to the interview guide (Annexure E).

In response to the opening question, semi-structured questions were asked to probe the participants further with regards to the following:

- The factors that influence the unit manager's leadership role.
- The challenges encountered in executing his/her leadership role; with further probes done based on the challenges mentioned.

- The needs of the unit manager with regards to his/her leadership role; and
- Suggestions for improvement to achieve efficient and effective leadership role.

Clarification of questions was carried out to obtain full explanation from the unit managers. The researcher asked other questions when the participant repeated information thus indicating a point of information saturation in their responses. Data saturation occurs when the participants no longer provide the researcher with new information and everything that has been said is repeated (Du Plooy-Celliers et al 2014:137).

The participants were encouraged to share experiences throughout the interview and allowed for addition of further information at the end of the interview; for feedback on important issues that the interviewee wished to still give but was not given an opportunity within the scope of the questions (Streubert & Carpenter 2011:157).

4.3.1 Challenges encountered during the interviews

The researcher was aware that the participants were busy and faced work pressures and deadlines. The following challenges were encountered during the interview processes:

- **Disturbances during interviews**

In one unit whilst busy with the interview, the staff kept knocking on door to find out when their enhanced performance development could be conducted. The participant also took a call from the landline, regarding a query about a bed from theatre. The researcher stopped the audio recorder and within a few minutes the interview continued. There was an intermittent drilling noise by maintenance in the unit and the disturbances diverted the attention of the participant. The researcher had to repeat questions.

In another unit, the unit manager's office doubled as a store room for consumables which resulted in interruptions by staff to fetch items. The unit manager informed the researcher as to the need to take cell phone and landline calls. The researcher on two occasions stopped the audio recorder and then resumed the interview after queries

from another unit staff member. At one point a staff member came in to discuss the condition of a patient, as the unit manager had a dual function as a shift leader as well. Noteworthy is that the unit manager informed the researcher prior to interview as to the possible disruptions.

In one unit the unit manager was affected emotionally by the tragic loss of a staff member a few days prior to the interview; who has been a source of support and mentor in the unit. The Personal Assistant (PA) of the unit manager interrupted to find out about the scheduling of an upcoming event for the public. The participant was not informed as to this awareness week and had to shift attention to the PA for a while before continuing with the interview.

- **Duration of the interview**

Two unit managers came late for the interviews due to personal and unit problems that needed their attention. Therefore the times were changed unexpectedly. In some instances the researcher found it difficult to limit the time of the interview, as some participants continued to talk and share concerns.

4.3.2 Positive aspects of the interviews

The participants were happy to share their challenges and experiences, viewed the interview as platform to vent their concerns and recognised the interview as an opportunity to bring about change through recommendations made. Furthermore, they enjoyed sharing their concerns with the researcher.

4.4 DATA ANALYSIS

Data analysis involved the resultant establishment of themes. The final written report includes the voices of participants, descriptions, interpretation of the problem and contribution from literature. As pointed out by Grove et al (2012:88), the data analysis was a rigorous, ongoing and emerging process. Data analysis took place after data collection and the researcher analysed data manually using the descriptive analysis method of Tesch 1990 as explained in Chapter 3 (De Vos et al 2011:397).

During manual analysis process

- Codes were written in abbreviated terms in the margins of the texts. A code is a symbol or abbreviations used to classify words or phrases. According to Brink et al (2012:193) describe coding as finding patterns and producing explanations using both inductive and deductive reasoning to categories data into segments.
- Descriptive words for topics were used and then sorted into categories. Categories are meaningful compartments on which the analysis is based.
- The number of categories were reduced by grouping similar topics together and showing how they interrelate.
- Finally, meaning units were attached to the categories.

4.5 RESEARCH FINDINGS

The participants' age ranged between 42 and 59 years. And their working experience as unit managers ranged from 3 to 10 years. These findings indicate that the unit managers were mature nurses who have been in the profession for a while and the experience as managers indicate that they had information regarding leadership roles. The manual analysis revealed three (3) topics, namely, factors influencing the leadership role of the unit manager, the challenges encountered by unit managers in their leadership role and the needs of unit managers. The themes, categories and attached meaning units are presented in the table 4.1 that follows.

Table 4.1 Themes, categories and meaning units

Theme	Category	Meaning unit
Theme 1 Factors influencing the leadership and management role in the unit	1.1 Structural experienced in the units	<ul style="list-style-type: none"> Physical structure and layout of the unit
	1.2 Roles and responsibilities of the unit manager	<ul style="list-style-type: none"> Too many responsibilities and multi tasks: quality initiatives, financial, human resources and supervision The UM responsible for constant supervision of staff Shortage of staff
	1.3 Communication in the unit	<ul style="list-style-type: none"> Lack of communication by nursing staff to patients, regarding procedures
	1.4 Autonomy issues	<ul style="list-style-type: none"> The UM requires more independence, and currently been told what to do and how to do
Theme 2 The challenges experienced by the unit manager in their leadership role	2.1 Qualification and competence of staff	<ul style="list-style-type: none"> Lack of competent staff to nurse patients Shift leaders not adequately trained Programme to be in place for newly qualified registered nurses
	2.2 Human resources and staffing matters	<ul style="list-style-type: none"> Human resources seen as punitive and not engaging staff
	2.3 Conflicts in the unit	<ul style="list-style-type: none"> Resistance to change
	2.4 New acuity model-nurse patient ratio	<ul style="list-style-type: none"> Acuity model makes no provision for emergency admissions, change of condition and post-operative complications Morale of staff is low
	2.5 Workload issues	<ul style="list-style-type: none"> Manager needs to take all responsibility and accountability All supervision done by UM, result in burnout Working long hours and overtime on weekends to cover the shortage of staff
	2.6 Existence of orientation programme for UM	<ul style="list-style-type: none"> UM not given an orientation to the unit, Given keys and passwords to computer UM does not know her expectations
Theme 3 The needs of the unit managers	3.1 Time management	<ul style="list-style-type: none"> No time for managerial responsibilities and involved in clinical work
	3.2 Remuneration and recognition	<ul style="list-style-type: none"> No recognition in terms of incentives and rewards Recognition and reward for expertise and excellence

4.3.1 Description of data

Deductive reasoning was used in the interpretation of data. The themes and categories are described in the section that follows.

Theme 1: Factors influencing the leadership and management role of the unit manager

The findings revealed the structural requirements of the units, roles and responsibilities of the unit manager, communication in the unit and autonomy issues in relation to the factors influencing the leadership and management roles. These were included as categories and are described in the section that follows.

Category 1.1: Structural experienced in the units

The findings indicated that the physical structure and layout of the unit made no provision for an office. In relation to the structure of the units, the findings revealed, there was no proper office for the unit manager or a storeroom. In one of the units, the unit manager's office doubled as a storeroom. This resulted in a challenge for the unit manager and difficulty in managing the unit as the unit manager needed to use treatment room or the patient's room to discuss staff or patient's concerns. Furthermore, there were constant interruptions from staff to fetch consumables from storeroom. According to the findings, the visitors' lounges were used as offices, which was inconvenient and not possible at times. The nurse unit managers empathised with staff and declared feelings of helplessness to change the situation as indicated in the following statements:

(UM-2): "There is no space in unit, therefore I share office and stock in one room."

(UM-5): "There are structural constraints and no office space. The office is at communal corner of nurse's station and there is no privacy."

Helgesen, Foldy and Sally (2008:28) indicates that a work place reflect bureaucratic divisions and hierarchical rankings, which communicate the power and status of a role. According to Kanter (2008:34) a lack of office space and support to perform management duties reflect a lack of power. The lack of office space could result in the nurse unit managers feeling undervalued and dissatisfied with their positions, which could in turn lead to frustration and dissatisfaction impacting on staff morale.

Sorensen and Severinsson (2008:535) indicate that interruptions have a negative impact on work procedures, workflow, ability to concentrate and reflective processes. Office space gives the unit managers potential to be more efficient. Office space speaks volumes and how a hospital values its staff. A good working environment could retain and enhance leadership of unit managers.

Category 1.2: Roles and responsibilities of the unit manager

The participants indicated that the unit manager's responsibilities and roles have significantly increased. They further indicated they were currently overwhelmed by carrying the roles of other unit nurses who were also shift leaders. The view of the participants was that their responsibilities involved more clinical work than administration and leadership tasks. The unit managers' changing roles and the immense responsibility have extended to checking if orders are carried out or medications given as per requirements, constant supervision of staff and personal assistants, nursing patients, stock ordering, organising staff as per acuity levels of the patients in the unit and attending meetings (or missing meetings due to workload). Furthermore, the participants mentioned that the unit managers were responsible to ensure all audits are complete in the unit in terms of occupational health and hygiene. The participants emphasised their feelings of being overwhelmed as unit managers as indicated in the following:

(UM-1): "The unit manager's focus is not just nursing."

(UM-2): "There is no quality staff to deliver quality care."

(UM-4): "I love what I do, but thought of stepping down. The stress is too much."

(UM-6): "I feel drained with office work, shift leading and working late."

It is evident from the participants' narratives that the unit managers are overwhelmed, as they are not only doing administration responsibilities but concentrating also on staffing issues to maintain quality care. Unplanned activities and interruptions are a major problem. The participants felt that the role of unit manager is constantly changing and increases stress levels.

Category 1.3: Communication in the unit

The participants mentioned that communication is pivot tool in the healthcare units to ensure quality and safe care rendered to patients. However, the findings indicated that the shift leaders lacked communication skills. There appears to be a lack of communication by nursing staff to patients, for example on procedures and medical explanation. The participants indicated delegation of staff was done, however, some instructions were not undertaken; which often resulted in unit managers having to do the tasks themselves. The participants said the following:

(UM-3): "I have open discussions with doctors and ensure non-blaming, non-finger pointing. I always have to come up with decisions."

(UM-4): "The unit manager needs to be open and approachable with people skills."

(UM-5): "We need group discussions to bring about change in communication."

Communication is challenging as each new participant, whether colleagues or healthcare providers, adds to the complexity by bringing in his/her own set of values and preferences to the situation. It seems role modelling by the unit manager would assist staff in communicating with different stakeholders and be confident.

Category 1.4: Autonomy issues

The participants suggested that more autonomy should be given to the unit managers with decision making. The participants stated:

(UM-1): "I need to be given more autonomy."

(UM-3): "Management is rigid; my challenge here is they don't allow you to carry on ideas."

(UM-5): "I need to allow staff to be flexible and be guided, and get staff to think."

The implications of providing greater autonomy has the likely effect to ensure unit managers make decisions and take accountability, whilst having the patients and staff's

best interest. Together with autonomy issues were support issues required from the unit manager. The participants indicated that they were responsible for all support services complaints, which impacted on their day to day running of the unit. The unit manager had to ensure all services are running smoothly in the unit. Issues included the following despite the fact that there were unit shift leaders, dedicated personnel and support staff:

- Catering- If the meal was not satisfactory or no water at patient's bedside, this resulted in a nursing complaint to be solved by the unit manager.
- Technical – If patients' lockers or door were broken, the unit manger would have to follow up with technical service and procurement.
- Cleaning services – When bathrooms not cleaned, the unit manager was responsible.

On the technical side the impact of having technical issues for the unit manager to resolve, resulting increased complaints from the patients. The participants strongly state that the technical supervisor should do rounds and supervise staff jobs.

Theme 2: The challenges experienced by the unit manager in their leadership role

This theme emerged with the following categories, namely, qualification and competence of staff, human resources and staffing matters, conflicts in the unit, new Acuity Model-Nurse patient Ratio, workload issues and orientation of the unit manager.

Category 2.1: Qualification and Competence of staff

Financial accountability and supervision of staff emerged as meaning units under this category. The unit managers mentioned their shortfall with financial management as part of their role and responsibility; whilst they have to take accountability for financial losses in their units. Interestingly, one participant indicated that she was comfortable with the financial accountability of the hospital, which could be attributed to her coming from a corporate environment and having exposure to financial accountability. The participants said:

(UM-3): “Financial terms are not understandable”.

(UM-5): “I cannot read financial statements”.

Some participants indicated that constant supervision was required as the units were short staffed or shift leaders not assertive or responsible. It seemed the unit managers were solely responsible in the units, and therefore needed to ensure all doctors’ orders and nurses’ documentation were carried out.

The participants stated that the lack of competent staff to nurse patients and lack of training for shift leaders. The participants mentioned that knowledge and skills are important for quality patient care. The impact of not having adequate skills to nurse patients, results in unit manager being involved in more clinical work rather than administrative work. The unit manager finds herself in crisis management daily. The following were said:

(UM-2): “We do not have skilled staff with relevant knowledge to do procedures, and this has a major impact on the manager to take responsibility.”

(UM-1): “Shift leaders are not taking accountability and responsibility to supervise staff, and this result with the unit manager to answer at the end of the day.”

(UM-6): “Skills of staff is not great, therefore the unit manager is always on the floor.”

The unit manager’s role is to arrange training for staff, which is not effectively done, due to time constraints. Clinical Nurse Specialists are allocated for teaching, end up nursing patients, due to shortage of staff. This impacts on no training been done in the units for the staff, resulting in no development of staff knowledge and skill.

Category 2.2: Human resources and staffing matters

This category relates to the challenges of inadequate staffing and human resources related to inability to recruit; and qualification and competence of staff. The participants mentioned that approving agency hours, logging of sigma calls and creating master files took up valuable management time. This could be done by personnel assistants. the participants mentioned that human resource staff are not present at interviews. The

impact of this is that another unit manager is required to do the interview. Interviewing of new staff with two unit managers was found to be unacceptable, as the Human Resources Department could be present to relieve one unit manager. Interviews of Personnel Assistants positions were done by the executive team which delayed the employment process and often resulted in losing the candidate.

This was as a commonly identified problem in all the units. The main challenge was having competent and skilled staff to render quality and efficient care to the patients. Furthermore, the findings indicate that shift leaders lacked training required for efficient operation in the units. The participants made several references to staff shortages which interfered with their management responsibilities. The performance of staff is another concern for participants, which results in a lot of frustration for participants. The participants' responses included:

(UM-3): "Shift leaders have patients of their own after 4pm, and cannot manage to supervise staff."

(UM-6): "Incompetent nurses in (unit name withheld for privacy) and no trust factor in, result in unit manager doing tasks for the patients."

This event impacted on the unit manager, in terms of taking her away from her managerial responsibility. The participants waste a lot of time supervising shift leaders and staff, which made their job more challenging. The participants indicated there should be a shared responsibility between them, shift leaders and staff to ensure all doctor's orders are carried out. Matlakala et al (2014:4) acknowledged the importance of having trained and experienced nurses in the units, however, the challenges to have efficient and adequate staff, was a global shortage of nursing staff. The human resource challenge remains recruitment of trained nurses. Buchan (2005:52) state that sufficient workforce capacity is required to enable health systems to function efficiently.

Category 2.3: Conflicts in the unit

The participants mentioned that doctor's issues have a major impact on their leadership in the unit. This is evidenced by the following responses:

(UM-6) (UM-2): “Doing doctors rounds the whole day, and doctors moods”.

(UM-1): “We need to keep our clients, the doctors satisfied”.

The participants indicated that doctors, need to do rounds with unit managers. This impacted on the managers’ roles as they needed to leave their tasks. Doctors displayed a lack of trust in staff carrying out orders. Doctors also conducted rounds at any time, resulting in patients complaining if not seen earlier and this results increased responsibilities for participants.

The participants emphasised their feelings of inadequacy as staff communicate their problems in the unit to doctors and management listen to doctors, rather than nurses.

(UM-2): “There are challenges with young and older surgeons in term of policies, medications dosing and communication.”

(UM-3): “I don’t pamper doctors; and too many doctors are allowed to complain, and go to senior management.”

This epitomises the scenario faced by the current context of unit managers in terms of the role of ethics with physicians in terms of Do Not Actively Resuscitate (DNAR). The participant had a challenge explaining the hospital group policy in terms of DNAR, as doctors were using international guidelines, which caused confusion to staff. It is evident that participant did not listen to staff concerns, which the participant later identified. Listening to staff concerns is crucial as a unit manager to ensure trust and continuity of care among staff.

The participants faced conflict issues daily with staff and other stakeholders. Management of conflict consumed the unit managers’ time. Team work and good interactions with staff is required. The participants mentioned that:

(UM-4): “Immediate consultation with staff members to resolve the conflict, communicate and encourage staff to come up with recommendations is essential.”

(UM-5): “Constant interaction and maintain communication with staff and provide feedback.”

(UM-6): “Using the non-blame approach positively impacts on good relationships within staff.”

According to Maxwell (2010:3), the four pillars and key features of successful leadership are relationships, equipping, leadership and attitude.

Category 2.4: New acuity model-nurse patient ratio

The participants mentioned that too many quality initiatives were rolled out at the same time. This made it difficult for the unit manager to follow through with patient rounding document or patient admission document. The impact of audits on the participants made it virtually impossible to complete all audits or qualities assure documents or delegate to other staff.

The new nursing acuity model introduced is called Daily Acuity Review Tool (DART). Acuity can be defined as the measurement of the intensity of nursing care required by a patient. An acuity based staffing system regulates the number of nurses on a shift according to the patients’ needs. The acuity level is expressed as the number of hours of nursing care required per patient per 24 hours.

The process of acuity monitoring is that the unit managers meet with the deputy nursing managers at 2pm daily to discuss the acuity and staffing of their units for the evening and next day. The night manager confirms all staff on duty and makes changes and submits a report to head office by midnight daily. If the acuity changes overnight, the unit manager would the next day respond with a motivation. Factors influencing acuity were nursing paid hours for 12 months, patient days, size of ward, skill mix and change in case mix. The following were the responses from participants with regard to the acuity model:

(UM-1): “The DART works as shift leader, do clinical work, and manage the staff.”

(UM-3): “Ward resource planning tool is not correct for the hospital.”

(UM-4): “The acuity model works, but does not accommodate for example emergency, admission, feeding other babies, etc.”

As indicated by the participants, the model makes no provision for emergencies or change of condition of patients. The acuity model makes the unit managers to become shift leaders which results in them unable to complete the administration responsibilities as they are on the floor involved in clinical work. The DART model commenced in July 2016, and it is evident that the training of the model was not adequate for the unit managers. The unit managers viewed the model as frustrating and indicated that management need is not aware of what is happening on the ground level. However, on a positive note, the model is good to develop responsibility, communication and accountability of staff with regard to staffing in the unit.

Category 2.5: Workload issues

The participants indicated that a large number of agency staff were used in the units, due to shortage of permanent trained and non-trained staff. This impacted on the unit management and there were concerns with lack of expertise, responsibility, accountability. The agency nurses were said to lack clinical judgement, had decreased skills and failed to report patients' problems. Responses across participants commonly raise issues of increased supervision, increased stress on permanent staff, allocation of non-trained staff to patients, lack of critical skills from agency staff and quality of care rendered to patients decreased. The participants indicated that they had to cover several rounds when agency staff were on duty. This is evidenced by the following responses:

(UM-1): “I do not get qualified registered nurses from agency to nurse patients.”

(UM-4): “One of my real challenges is working with agency staff. Skills is a huge problem, difficult to address, even though you teach them.”

(UM-6): "Agency staff have no critical background. They have limited skills and don't care attitude, as they will go elsewhere tomorrow."

The participants indicated that there is insufficient skilled staff to deliver quality care. This results in the unit manager taking all responsibility and accountability. Some participants ended up working after 4pm and weekends to cover the shortage of staff in their units. Total supervision was done by the unit managers as well; and therefore the shortage of nurses made it difficult to encourage nurses to take up leadership positions. Some participants felt inadequate about leading their units. The impact of this support services came across from participants as being vitally important to ensure services and job responsibilities to be done by the support staff. This will reduce the workload on the participants, and will results in participants concentrating on staff leadership and managing the units.

Category 2.6: Existence of orientation programme for UM

Some participants indicated they were not given orientation as unit a managers as stated in the following:

(UM-3): "I was just given keys to the office and passwords to computers."

(UM-6): "I walked to the unit myself."

This scenario resulted in participants not being orientated to the vision and requirements of the institution. The participants were of a common view that it is important that all unit managers be given an orientation to ensure effective leadership and management in the unit. This would be essential especially because the unit mangers as leaders in their units also needed to orientate their newly employed staff.

The participants additionally mentioned that newly qualified registered nurses had no structured orientation programme which resulted in the unit manager having to orientate the registered nurse on administrative responsibilities. Due to the shortage of staff mentorship of new registered nurses was not always possible. This coupled with the unit manager's own lack of orientation brought about some challenges with the leadership role of the unit managers.

Theme 3: The needs of the unit managers in relation to their leadership roles

This theme included the need for time management in the unit, and remuneration and recognition. Based on the previous themes, the participants indicated a desperate need for a support strategy, mentorship or coaching programme to be implemented for unit managers. The participants mentioned that the unit management course offered by the hospital is not adequate for the leadership and management of unit for the managers. Due to constant change in the health sector, policies and new development, unit managers need to be updated and kept abreast to ensure that they are developed, competent and effective as leaders. The participants indicated that they need to be technologically savvy, willing to take risks, develop confidence in one's own abilities and being visionary and systems orientated thinking and the leadership need to be sustainable. Autonomy was mentioned as the key to taking on responsibility and accountability, and therefore they wished to be given a chance to work independently following the hospital policies.

Category 3.1: Time management

The participants mentioned that they had limited time to complete tasks as they were more involved in clinical work and managerial tasks were neglected. The nature and magnitude of resource constraints were indicated by participants complaining of time taken to for example find beds, transfer patients, etc. One participant explained:

(UM-1): "I felt like I have not done anything, tasks the whole day. My plan to see staff and teaching staff never materialises."

The participants further indicated that they were overwhelmed with audits and reports that were due on a daily, weekly and monthly basis. They need to be influential, motivate and delegate to staff to take responsibility on tasks.

Category 3.2: Remuneration and recognition

A participant challenged human resources department in terms of the performance management called EPD programme. It was stated that high or low performers earned

the same salary increase. This resulted in demotivated staff as staff required incentives, rewards and appreciation such as certificates, which were suggested by one participant. The human resources processes were mentioned by one participant as negative to supporting staff and development. The morale of the staff seemed to be down and was around issues of being overworked.

(UM-5): "I am overworked and cannot account for what has been done."

The participants indicated that their concerns need to be addressed, to ensure participants are happy or this could negatively impact on staff and their morale. It was further indicated that unit managers do not get a specialty allowance when nursing patients. The participants were of the opinion that there was a discrepancy of salaries even though management had indicated that this was not the case in point. Staff and unit managements were said not to receive recognition in terms of incentives or rewards. One participant said:

(UM-3): "Only on nurse's day would you get a mug."

The participants indicated that other rewards need to be developed, to motivate unit managers and for staff to feel valued and appreciated, for example, on birthdays of staff, employer of the month, etc.

4.7 DISCUSSION AND INTERPRETATION OF THE FINDINGS

The participants indicated they have a combination of autocratic, participative and situational leadership. However, transformational leadership should be the way forward in management. From the roles and responsibilities of the unit managers, it was evident that leadership involved many other issues such as leadership in role modelling, leadership in financial management in the unit, leadership in communication, autonomy, conflict management, induction and training of staff, time management, performance management and recognition of staff, and human resources management and staffing in the units.

- **Factors influencing the leadership and management role in the unit**

When exploring the working environment of nurse unit managers, the observations from the findings provided a valuable record of the presence or absence of power symbols such as adequate office space. The findings revealed that there were no appropriate offices for the unit managers, which impacted on the management of the unit. Problems arose when managers needed to carry their daily administrative duties, discuss personal issues or counselling of staff. Constant interruptions in offices that doubled as storerooms impacted on the manager to continue his administration work. While the interruptions and unplanned activities were not unexpected, the nature of interruptions gave insight to the practice environment of the unit managers. Sorensen and Severinson (2008:535) indicate that interruptions have a negative impact on work procedures, workflow, ability to concentrate, reflective processes and interaction with patients

Furthermore, a manager and leader may not feel valued by the fact that they are not allocated an office for private interaction with staff. As a leader, the unit manager needs to feel valued; and not having an office does not allow private interaction with staff. It is evident that it is inconvenient for the unit manager to discuss in the treatment rooms or patients' rooms matters regarding concerns with staff. According to Duffield, Roche, Blay and Stasa (2011:23) nursing leadership plays a role in retention through the creation of positive workplaces.

It was interesting to note that some participants had some knowledge of financial management of the unit. However, the participants mentioned the need for training on the interpretation of financial statements and the terms associated with finances in the healthcare unit. The participants recognised leadership in financial management understanding as being of utmost importance to manage units. It is evident that the unit managers need additional training and/or a refresher session on for example reading and interpreting financial statement per unit, patient bills, stock costs, agency costs, etc. This will assist them to understand the financial management in the unit, as the hospital is a business and this has an impact on stock losses and consumables

It was revealed that the unit manager as a leader needs to ensure communication with doctors and other stakeholders in the unit and the hospital at large. According to

Shortell (2013:506) poor communication is the most frequent and critical problem, both within a group as well as between the leader and the group and often leads to errors and create conflicts. Therefore the skill of interpersonal communication is one of the most important individual qualities of a leader

With regards to autonomy issues, it is evident that the unit managers need to be trusted and not micro managed. It is evident from the study that unit managers require more autonomy. This will allow unit managers to take responsibility for actions and come up with innovative ideas to assist the ever-changing health care setting and promoting a pleasant and enjoyable work environment.

- **The challenges experienced by the unit manager in their leadership role**

The study revealed that unit managers provided continuous supervision to staff, resulting in no empowerment of shift leaders or staff. Lack of skill and clinical knowledge of staff in the working environments was indicated to lead to increased responsibility and accountability for the unit manager due to the fact that they are on the floor supervising. This has an impact on the manager being unable to get time to manage the unit and address staff concerns. The quality of care of patients was affected as well, limiting the effectiveness of the unit manager as a leader.

It seems that some of the staff did not have the necessary skills to be independent shift leaders. This resulted in added pressure for the unit manager, as there was a lack of delegation skills and accountability. The study indicates a need for unit training and/or workshop for the current shift leaders on their roles and responsibilities. The benefits of the orientation programme would be represented through an effective shift leader ensuring that quality nursing care rendered.

The use of agency staff with limited knowledge and skills to work in various units resulted in the unit manager having to continuously supervise agency staff, limiting the time available to concentrate on administration. Harir, Salisbury, Johannsson and Redfern-Vance (2014:142) suggest that nursing leadership is essential for best practise, better working conditions; including appropriate staffing levels, which are linked to nurses' job satisfaction.

The unit managers seemed not happy with the new acuity model introduced for the hospital as it rendered them tired, overworked and not feel effective as leaders. Even though the acuity model made provision for proactive planning for staff and increases communication and engagement within units and managers, these benefits did not seem to be realised.

The findings indicated that numerous quality initiatives were being rolled out simultaneously, which impacted on the unit managers' ability to keep up with their leadership in quality audits and resulted in compliance being compromised. It can be safely indicated that proper quality initiatives need to be streamlined with the focus being quality patient care and explanations to staff, thereby ensuring compliance.

The findings revealed staffing and workload as daily challenges affecting leadership in quality care and responsibilities of the unit managers. This resulted in frustration, inadequacies and feelings of helplessness due to the fact that the managers were accountable and responsible for all actions in the units. This suggests that the matter of staff taking ownership and responsibility needs to be addressed. The unit manager who has to constantly supervise staff can result in burnout and lack of empowerment to staff. It seems there was a lack of understanding of the when to use the various leadership styles, which impacted expected leadership outcomes.

With regards to the lack for orientation programmes which negatively impacts on the unit managers' leadership role; this is viewed as a vital need as it is the grounding for the unit managers' leadership role.

- **The needs of the unit managers**

The findings revealed increased administration responsibility for the unit managers. A strategy for time management needs to be addressed for unit managers as it is clearly evident that the unit managers lacked time management skills due to the many roles and responsibilities. The increased working hours of the unit manager (after 4 pm and weekends), resulted in unit manager having to crisis manage rather than effecting strategies for the unit. Locke, Kitsell and Griffith (2011:177) indicate that an increased administration responsibility can draw nurse unit managers away from clinical

leadership, mentoring and communicating with their staff; which reduces their capacity to provide day to day leadership and develop a strategic vision for the unit

Time management seems to be a problem as indicated by unit managers having to deliver on tasks and meeting deadlines at the same time. Unit managers were found to be working long hours to satisfy management and deliver on effective patient care. Leadership role modelling is the expectation of a unit manager; however, they find themselves more involved in clinical work, than leadership tasks. Therefore there is a definite need to balance tasks and ensure that priorities are met.

The findings revealed that the enhanced performance management programme consumed a lot of time for the unit managers; involving staff evaluation and goal setting. However, it seems in monetary terms, all unit managers get the same percentage salary increase with the rest of the staff. The findings indicate that remuneration of unit managers needs to be addressed when clinical work is done. Rewards and incentives need to be in place, thereby motivating staff and increasing the morale of the unit.

Non-nursing duties such as stock checking resulted in added responsibility to unit managers. It is safe to say the unit managers need to have effective personnel, to ensure all tasks are undertaken. According to Garling (2008:134), nurse unit managers spent more time on non-clinical responsibilities, which take them away from leading and supervising patient care. There can be role conflict between managerial duties and patient care can be reflected with adverse events.

The findings revealed a need for a support strategy to develop unit managers in their mentorship and coaching programme. It was noted that current Emotional Intelligence workshop held by management is beneficial to unit managers. However, the sessions occurring every three months, results in unit managers losing the focus of the course. The researcher suggests ongoing training, should keep managers focused, and increase motivation and encourage sharing of ideas.

There should be sharing of protocols between hospitals to ensure consistency and for staff to be familiar with protocols, at all hospitals. This study indicates there is an impact on service rendered to patients, evidenced by complaints received from patients. The unit manager is responsible for all services in the unit, such as catering, maintenance,

etc. The support services and management need to ensure services are well maintained in the units. This is additional work on the unit manager to oversee this as well, ensuring patients are content with services and establishing and maintaining relationships with support services.

It is evident from the study that unit managers require more autonomy; this will allow unit managers to take responsibility for actions and come up with innovative ideas to assist the ever-changing health care setting. The environment should be a pleasant and enjoyable to work in. Some participants suggested a budget to be given to units to, as guide to cost initiative processes.

The study indicates staffing and workload of unit managers is daily challenge; including inadequate skilled staffing to deliver quality care. This results in frustration and inadequacies of the unit manager and feeling helpless. The manager is accountable and responsible for all actions in the units. This needs to be addressed and staff need to take ownership and appropriate disciplinary actions for staff and identify staff concerns as well. The unit manager has to constantly supervise which can result in burnout. There is lack of empowerment of staff. Resolving conflicts and ensuring harmony in the unit is the responsibility of the unit manager.

Remuneration of unit managers needs to be looked at when clinical work is done. Rewards and Incentives need to be in place, thereby motivating staff and increasing the morale of the unit. Staff need to be made aware of the facility as businesses such as introducing measures to save costs. Very limited literature was found as the topic had not been previously researched.

4.8 CONCLUSION

This chapter described in detail the data collection process, analysis, interpretation and discussion of the findings. Data were supported with literature. The next chapter presents the strategy for nurse unit managers to overcome challenges in their leadership role.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of this chapter is to present the study limitations, conclusions and recommendations about the findings of this study. The purpose of the study was to develop a support strategy for unit managers to achieve success in their leadership role in a specific private hospital in Gauteng Province. The researcher analysed the current leadership context of nurse unit managers and developed possible solutions that may positively contribute to their leadership role. A strategy was developed based on the findings of this study and presented to the executive team of the hospital, that is, the General Manager and Nursing Service Manager for validation.

5.2 SUMMARY OF RESEARCH DESIGN AND METHOD

A qualitative, exploratory and descriptive design was used. The qualitative approach was used because the researcher needed to obtain information from nurse unit managers through exploration of the challenges they experienced in their leadership roles within their units. Data were collected through semi-structured individual interviews. The target population were unit managers working in the selected units. The selection of nurse unit managers was based on them having more than one year of management experience in various units.

Data were analysed manually using open coding, whereby factors, challenges and needs of the unit managers were identified and subsequently outlined as three emerging themes; with each theme having different categories and meaning units.

5.3 SUMMARY OF THE RESEARCH FINDINGS

Three themes emerged in the analysis of the data, namely:

5.3.1 Theme 1: Factors influencing the leadership and management role in the unit

The operational space of the unit managers affected the leadership ability and management of the unit when no office space was allocated or storerooms were utilised as offices. Key factors that negatively affected leadership effectiveness were staff privacy, establishment of trust relationships, development of effective strategies and efficient reporting. It was observed that nursing unit managers were also limited in their aspirations and showed low morale. The lack of support from the hospital management undervalued the role of the nurse unit managers, which emerged as a key finding out of the interview data. The study indicates a need for a support strategy to develop unit managers in their task completion or mentorship and coaching programme.

The roles and responsibilities of nurse unit managers needed to be clearly defined and realistically clarified by hospital executive management. It was evident that the current unit managers were overwhelmed with the responsibility which included supervision, quality initiatives and financial management in the unit. The unit manager is responsible for financial management in the unit, for example of agency costs and consumables costs. It is evident that some participants need training on the interpretation of financial statements and terms associated with financials. The training done in the unit manager course is evidently not sufficient. However, financial understanding is of utmost important to manage units and communicate with staff and to ensure compliance. A budget should be made available to units to guide cost initiative processes as an exercise for leadership in financial management of the unit. Staff need to be made aware of the facility as businesses e.g. introduce measures to save costs.

Unit managers were given responsibility and accountability to manage their units independently but with limited autonomy, thus negatively impacting management of patient care. Ineffective communication by staff regarding the procedures to patients and shift leaders to unit managers impacted on unit managers' ability to resolve complaints effectively.

5.3.2 Theme 2: The challenges experienced by the unit manager in their leadership role

A key challenge identified is the lack of knowledgeable, competent and efficient staff. As a result shift leaders are restricted with delegation ability and resulting in conflicts which impacts negatively on leadership and nursing care. Shortages of qualified registered nurses in critical care units are overcome by the use of agency staff, thus compromising sustainability in training efforts. No organised training programme is in place to support staff development.

Although mostly appropriately selected nurses across the hospital are promoted into nurse managers role, this does not necessarily result in competent nurses when prematurely promoted or promoted without the relevant orientation support. The orientation required for nurse managers need to adequately cover leadership and business skills needed to be successful in running a nursing unit, as well as a global perspective of the healthcare industry and new practises and trends, which is clearly lacking, thus compromising effective nursing and patient care management. The end result is that the organisation is at risk of losing top nursing talent.

Inadequate communication both within a group as well as between the leader and the group leads to errors and promote conflict. The new acuity models results in unit managers' being more involved in clinical work and shift leading the unit. The role of unit the manager often changes from that of a unit manager to being a functional nurse responsible for direct patient care (Matlakala et al 2014:6) as well shift leading in units. The study indicated that unit managers spent most time on supervision; due to the complexity of the nursing tasks or due to staff shortages. Although it is encouraging to note that unit managers spent a large proportion of time on patient care, this appears to result in limited time to carry out management or leadership responsibilities. Leadership of the unit managers was challenged by stress in terms of the heavy workload and low morale. This is due to the misconceptions of the acuity model programme being seen as managing hours and being financially linked rather than being seen as managing patient care. The unit managers concerns with regard to the acuity model, needs to be discussed with management, to review the acuity model to ensure its maximum utilisation.

5.3.3 Theme 3: The needs of the unit manager

The ability of the nurse unit managers to balance conflicting demands and provide effective leadership depends not only on their preparation for leadership roles, but also the organisation's support given in terms of time and staff. Nurse unit managers are the gatekeepers of high standards being met on a daily basis, increases staff and patient satisfaction and assist with recruitment and retaining of nursing talent. Nurse unit managers play a critical role in creating a positive work environment, which results in increased job satisfaction for staff. It is essential that the executive level of management recognise the need for nurse unit managers to develop expertise and leadership in the private health sector.

Time-consuming activities carried out by nurse unit managers are believed to negatively affect the quality of care in the units. Unit managers may greatly benefit from time management and organisational skills development to multitask for a heavy workload. In this private healthcare industry there seem to be a general lack of recognition of the importance of unit managers' role in driving change and the importance of formally involving nurse unit managers as leaders is not always recognised.

5.4 CONCLUSION

The conclusions are discussed under the different themes, acknowledging the responses from participants. The conclusions were achieved through inductive and deductive reasoning following data analysis. The factors influencing the leadership and management roles were related to the challenges encountered by nurse unit managers in running their units. The findings indicate that a key need required of the unit manager is support and direction from executive management.

The overall conclusion from this study is that nurse unit managers encounter a number of challenges in the leadership of their units. It is difficult to apply the leadership and management process effectively, due to ineffective/unskilled staff, unplanned activities and changing role of nursing unit managers. Therefore the strategy is required to assist and develop current nurse unit manager's leadership role. From the needs expressed by the nurse unit managers, ideas were formulated by the researcher to support the

development of a strategy to support the unit managers in their leadership role. The strategy includes eight key elements and is presented in the section that follows.

5.5 SUPPORT STRATEGY FOR EFFECTIVE LEADERSHIP FOR THE NURSE UNIT MANAGERS

Key element 1: Develop and clarify the role and responsibilities of nurse unit managers to support effective leadership.

Key element 2: Develop and implement strategies for communication and autonomy to support nurse unit managers.

Key element 3: Define the development required to support highly skilled, efficient, and effective shift leaders to ensure quality nursing care and supervision of staff.

Key element 4: Orientate nursing staff to understand and effectively implement the acuity model. The unit managers' concerns with regard to the acuity model needs to be discussed with management, to review the acuity model to ensure its maximum utilisation.

Key element 5: Develop and implement strategies that will assist unit managers with workload which will promote effective leadership skills.

Key element 6: Orientation of new unit managers to include the vision of the hospital, leadership and business skills. Emotional Intelligence workshops and sessions should be ongoing training to keep managers focused, and increase motivation and encourage sharing of ideas.

Key element 7: Develop and implement time and organisational management strategy for effective unit management.

Key element 8: Develop and implement a strategy for remuneration and recognition of nurse unit managers that promotes leadership effectiveness and efficiency.

Key element 9: Develop and implement a programme for in-service education in financial management.

5.6 RECOMMENDATIONS

The following recommendations are made in relation to the findings of the study under nursing leadership and management, education and research and nursing practice:

5.6.1 Recommendation for nursing leadership and management:

- Nurse unit managers should make use of transformational leadership, as nurse physician collaboration and group cohesion results in empowering and retaining staff. Staff involved in obtaining solution to problems, leads to team spirit, job satisfaction and cost effectiveness.
- Hospital managers to encourage leadership among staff, set new directions, empower and enable staff to make decisions and solve problems.
- Nurse unit managers to plan, organise, staff, provide direction and control to ensure attainment of the organisation's goals and to maintain healthy relationships among staff.
- Empowering nurse unit managers to address conflict and to constructively resolve problems through initiatives such as an ethics programme and. establishing a code of conduct that is values based.
- Hospital management to support unit managers as leaders to develop the skills of role modelling, expertise, knowledge and orientated thinking regarding the organisation's goals in collaboration with others.
- The hospital manager should develop excellent communication skills that are essential for effective leadership that motivate staff.
- The hospital should devise means for reduction and division of workload
- Nurse unit managers need to be involved in strategic planning regarding their staff concerns and decisions on the departments' structure.
- Unit managers should be given full autonomy and authority to manage their units, in keeping within hospital policies and standards.
- The responsibilities of the nurse unit managers need to be reviewed to ensure they have sufficient time for managerial and leadership responsibilities.

- Innovative recognition and reward systems need to be developed such as reflective appreciation in the form of for example yearly weekend away team building.
- Retraining and clarifying the acuity model to managers and staff to dismiss misconceptions and emphasise the benefits to quality patient care.
- Involvement of nurse unit managers in policy and protocol development in collaboration with physicians.
- Permanent and agency staff should be orientated and accountable making them responsible for maintaining high standards of competence in quality nursing care.

5.6.2 Recommendations for education

This research recommends the following with respect to nursing management/leadership education:

- Extensive leadership training is required for the nurse unit managers to address the change management role they fulfil within institutions and to address shortcomings in managerial and leadership skills through short courses and human resource development programmes.
- Extensive orientation programmes for new managers in terms of administrative tasks as well as leadership and business skills. .
- Shift leader workshops quarterly to assist in decision making and effective leadership.
- Development of leadership and management training, refresher courses and workshops related to nurse unit managers, thereby updating knowledge and skill.
- Emotional intelligence leadership workshops to assist dysfunctional workplace relationships, values and conflict.
- Work-life balance and coaching in leadership and leadership skills for unit managers
- Mentorship programme linked to the orientation so that there is sustainability the staff been trained and skills enhanced.
- All nursing units to have updated doctor's protocols which are reviewed yearly and staff must be made aware of changes.

- Education programmes to be developed for agency staff to work in units should be done prior to working. Consultation with the various agencies to ensure it is complete is also necessary.
- Continuous professional development of nursing staff and nurse unit managers to guide professional practice and enhance nurse's clinical competence to contribute to job satisfaction and a stable workforce.

5.6.3 Recommendations for research and nursing practice

Based on this study, further research is recommended on the following:

- Evaluation of the effectiveness of the leadership training and workshops provided to nurse unit managers.
- Development of ongoing leadership training programmes for all unit managers in private hospitals in Gauteng.
- Further research into the efficiency of the strategy as an intervention to meeting the challenges encountered by nurse unit manager, needs to be conducted.
- The challenges of nurse service managers to be explored in terms of unit managers with a view to developing a comprehensive approach to address problems identified and to draw on the innovative solutions.
- Factors that increase the quality of nursing care in units to be evaluated or analysed by nursing unit managers.

5.7 CONTRIBUTION OF THE STUDY AND DISSEMINATION OF THE FINDINGS

The factors, challenges and needs experienced by nurse unit managers in the leadership of their units were explored and described. The study will contribute towards proposing solutions to address the leadership challenges encountered by nurse unit managers. Three major themes emerged from the study and provided a framework for developing a strategy to promote effective leadership. The researcher will communicate the findings of the study to hospital executive team members and regional executive nursing office staff in Gauteng. The findings of the study will be disseminated through presentation at the nursing meetings and executive management meetings and conferences. The findings may make the management of the hospital aware of the

challenges faced by the current unit managers. All unit managers who participated in the individual interviews, together with other unit managers and stakeholders will be invited to attend the workshops organised by the researcher and approved by the hospital. The workshop venue will be at the hospital. The themes and strategies will be presented to the nurse unit managers, thereby allowing for an interactive session. The final results will be disseminated to a nursing management journal in South Africa.

5.8 LIMITATIONS OF THE STUDY

The scope of this study is only the leadership role of the nursing unit manager. The researcher applied the study to clearly defined structures of nursing leadership, a specific setting of a private hospital and limited the study to the two levels of nursing management, that is, nursing management and deputy nursing management in this research study.

Grove et al (2012:198) highlights that limitations are restrictions or problems in a study that may decrease the generalising of the findings. The limitations were that the study was conducted in one private hospital in Gauteng, therefore the findings cannot be generalised to other hospitals. The challenges identified were based on the views of six unit managers in one private hospital. This limits the application of the findings to other unit managers and hospitals in Gauteng. The acuity model that had just been implemented a few months before data collection for this study could have impacted on the lack of effectiveness in its application by unit managers as it was relatively new. The findings may have been different if participants from other hospitals were included. The times of the interviews were limited due to business of the nursing units and the availability of the unit managers.

5.9 CONCLUDING REMARKS

The unit managers described leadership challenges experienced by in their management and leadership of the unit. The challenges were related to the physical structure and layout, roles and responsibilities of the unit manager, that is, supervision, human resource, financial, quality initiatives, communication, autonomy, conflicts, workload issues and, orientation of the unit managers.

The study findings revealed the need for a support strategy for nurse unit managers in their leadership role. A strategy was developed which suggested ways to overcome or manage the challenges identified by the nurse unit managers. The proposed strategy is envisaged to can alleviate some of the challenges noted by the nurse unit managers.

5.10 PERSONAL REFLECTION

Undertaking this study has been rewarding through the revelation of the ardent need to support the nursing sector and resultant enhanced patient care. The researcher's understanding of leadership in nursing has expanded prolifically and the sharing of information by participants has been humbling.

The researcher is of the belief that the proposed strategies will be a significant contribution to creating new knowledge in nursing leadership. Nursing leadership is essential to secure skilled nursing staff, design innovative models of care, and embed strong financial performance and patient safety within the healthcare system.

The opportunity exists for nurse unit managers to lead an effective and efficient healthcare system, by being a valuable resource with the potential to make a significant contribution to the transformation of private healthcare in South Africa.

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ANNEXURES

ANNEXURE A

Ethical clearance certificate



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

REC-012714-039

HS HDC/422/2015

Date: 17 June 2015

Student No: 0721-916-4

Project Title: Leadership challenges encountered by nurse unit managers in a private hospital in Gauteng Province.

Researcher: Magesh Naidoo

Degree: MA in Nursing Science

Code: MPCHS94

Supervisor: Prof MC Matlakala

Qualification: D Litt et Phil

Joint Supervisor: -

DECISION OF COMMITTEE

Approved



Conditionally Approved



for Prof L Roets

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

L. A. Roets (Prof.)

for Prof MM Moleki

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B

Letter requesting permission to conduct the study

Ms Magesh Naidoo
PO BOX 2945
Honeydew
2040

The Hospital General Manager
Netcare Olivedale Hospital
Johannesburg
Gauteng

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN HOSPITAL

Dear Hospital/General Manager

My name is Magesh Naidoo, and I am a Masters in Nursing Science student at the University of South Africa (UNISA). As part of the requirement for the study, I have to conduct a research project. The topic for my research project is "Leadership challenges encountered by nurse unit managers in private hospitals in Gauteng". This study will be conducted under the supervision of Prof MC Matlakala (UNISA, South Africa).

I hereby request for permission to conduct research at Netcare Olivedale Hospital.

I hereby attach a copy of the research proposal and the ethical clearance certificate from the academic institution.

If you require any further information, please do not hesitate to contact me on 0829093787, naikerm@yahoo.com.

Thank you for your time and consideration in this matter.

Yours sincerely

Ms Magesh Naidoo

ANNEXURE C

Hospital approval to conduct the study

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2015-0069

Ms Magesh Naidoo

E mail: naikerm@yahoo.com

Dear Ms Naidoo

RE: LEADERSHIP CHALLENGES ENCOUNTERED BY NURSE UNIT MANAGERS IN PRIVATE HOSPITALS IN GAUTENG

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Committee.
- ii) All information regarding the Company will be treated as legally privileged and confidential.
- iii) The Company's name will not be mentioned without written consent from the Committee.
- iv) All legal requirements with regards to participants' rights and confidentiality will be complied with.
- v) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.
- vi) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date..
- vii) The Company has the right to implement any recommendations from the research.



ANNEXURE D

Informed consent to participate in the study

I am Magesh Naidoo, a post graduate student registered for the Master of Arts (Health Studies) programme at the University of South Africa. As part of my study, I am required to conduct a research project.

The topic for my research project is: **“Leadership challenges encountered by nursing unit managers in a private hospital in Gauteng, South Africa”**.

The purpose of the study is to develop support strategy for unit managers to achieve success in their leadership role.

You are requested to voluntarily participate in the study and therefore to take part in the individual interviews that will be conducted. You may withdraw from the study at any time and your name will only appear on the consent form. All information furnished will be treated with strict confidence. Although there are no financial benefits for you in participating, the study results will be used to design support strategy for unit managers to achieve success in their leadership role.

If you require any further information, please do not hesitate to contact me on 0829093787, naikerm@yahoo.com.

Thank you for your co-operation and support, please sign below to acknowledge your agreement to participate in this study.

I, (full name and surname) _____ have read and understood the informed consent; and agree to participate.

Signature of participant.....

Signature of witness.....

Date.....

ANNEXURE E

Data collection tool

Student: Magesh Naidoo

Student number: 07219164

Title: Leadership challenges encountered by nurse unit managers in a private hospital in Gauteng Province

The central question for the individual unstructured interview will be: "Kindly tell me about your leadership role in your unit"

The focus of the interview will be on:

1. What are the factors that influence your leadership role?
2. What are the challenges you encounter in executing your leadership role? Further probes will be done based on the challenges mentioned.
3. What do you need as a unit manager with regards to your leadership role?
4. What would you recommend for improvement to achieve effective leadership role?